APPENDIX 1   EDIT CODES, CARCS/RARCS, AND RESOLUTIONS

Edit Code	Description	CARC	RARC	Resolution
007	PAT DAILY INCOME RATE MORE THAN HOME RATE	45- Charge exceeds fee schedule/maximum allowable or contracted/legislated fee arrangement.		Patient's daily recurring income is greater than the nursing facility's daily rate. Verify that you have provided the correct information. Contact your program representative regarding any discrepancies.
050	DATE OF BIRTH/ DATE OF SERV. INCONSISTENT	14 - The date of birth follows the date of service.	M52 - Incomplete/invalid "from" date(s) of service.	**CMS-1500 CLAIM:** Verify that the Medicaid ID# in field 2, date of birth in field 11, and date of service in field 15 were billed correctly. If incorrect, make the appropriate correction. If the date of birth in field 11 is correct according to your records, contact the local county Medicaid office. **UB CLAIM:** Verify that the Medicaid ID# in field 60, date of birth in field 10, and date of service in field 6 were billed correctly. If incorrect, make the appropriate correction. If the date of birth in field 10 is correct according to your records, contact the local county Medicaid office. **All other provider/claim types**: Contact your program representative.
051	DATE OF DEATH/ DATE OF SERV INCONSISTENT	13 - The date of death precedes the date of service.	M59 - Incomplete/ invalid "to" date(s) of service.	**CMS-1500 CLAIM:** Verify that the correct Medicaid ID# in field 2 and date of service in field 15 were billed. If incorrect, make the appropriate correction. If correct, contact the local county Medicaid office to see if there is an error with the patient's date of death. **UB CLAIM:** Verify that the correct Medicaid ID# in field 60 and date of service in field 6 were billed. If incorrect, make the appropriate correction. If correct, contact the local county Medicaid office to see if there is an error with the patient's date of death. **All other provider/claim types**: Contact your program representative.
052	DMR WAIVER CLM FOR NON DMR WAIVER RECIP	141 - Claim adjustment because the claim spans eligible and ineligible periods of coverage.	N30 - Recipient ineligible for this service.	The claim was submitted with a MR/RD waiver-specific procedure code, but the recipient was not a participant in the MR/RD waiver. Check for error in using the incorrect procedure code. If the procedure code is incorrect, strike through the incorrect code and write the correct code above it. Check for correct recipient Medicaid number. If the recipient's Medicaid number is incorrect, strike through the incorrect number and enter the correct Medicaid number above it. Submit the edit correction form with the MR/RD waiver referral form attached. If the recipient Medicaid number is correct, the procedure code is correct, and a MR/RD waiver form has been obtained, contact the service coordinator listed at the bottom of the waiver form.

APPENDIX 1   EDIT CODES, CARCS/RARCS, AND RESOLUTIONS

Edit Code	Description	CARC	RARC	Resolution
053	NON DMR WAIVER CLM FOR DMR WAIVER RECIP	141 - Claim adjustment because the claim spans eligible and ineligible periods of coverage.	N34 - Incorrect claim for this service.	Please check to make sure you have billed the correct Medicaid number, procedure code, and that this client is in the MR/RD waiver. If you have not billed either the correct Medicaid number or procedure code, or the client is not in the MR/RD waiver, re-bill the claim with the correct information. If the correct information has been billed and you continue to receive this edit please contact your program representative.
055	MEDICARE B ONLY SUFFIX WITH A COVERAGE	16 – Claim/service lacks information which is needed for adjudication.	MA04 - Secondary payment cannot be considered without the identity of or payment information from the primary payer. The information was either not reported or was illegible.	Submit a claim to Medicare Part A.
056	MEDICARE B ONLY SUFFIX/NO A COV/NO 620	16 – Claim/service lacks information which is needed for adjudication.	M56 - Incomplete/invalid provider payer identification.	Enter Medicare carrier code 620, Part A - Mutual of Omaha carrier code 635, or Part B - Mutual of Omaha carrier code 636 in field 50 A through C line. Enter the Medicare Part B payment in field 54 A through C. Enter the Medicare ID number in field 60 A through C. The carrier code, payment, and ID number should be entered on the same lettered line, A, B, or C.
057	MEDICARE B ONLY SUFFIX/NO A COV/NO $	107 - Claim/service denied because the related or qualifying claim/service was not paid or identified on the claim		Enter Medicare carrier code 620, Part A - Mutual of Omaha carrier code 635, or Part B - Mutual of Omaha carrier code 636 in field 54 A through C line which corresponds with the line on which you entered the Medicare carrier code field 50 A through C.
058	RECIP NOT ELIG FOR MED. FRAGILE CARE SVCS	141 - Claim adjustment because the claim spans eligible and ineligible periods of coverage.	N30 - Recipient ineligible for this service.	Contact your program representative.
059	MED. FRAGILE CARE RECIP SVCS REQUIRE PA	15- The authorization number is missing, invalid, or does not apply to the billed services or provider.	M62 - Incomplete/invalid treatment authorization code.	Contact recipient's PCP to obtain authorization for this service.
060	MED. FRAGILE CARE, CLAIM TYPE NOT ALLOWED	16 – Claim/service lacks information which is needed for adjudication.	N34 - Incorrect claim for this service.	Contact your program representative.

APPENDIX 1   EDIT CODES, CARCS/RARCS, AND RESOLUTIONS

Edit Code	Description	CARC	RARC	Resolution
061	INMATE RECIP ELIG FOR EMER INST SVC ONLY	141 - Claim adjustment because the claim spans eligible and ineligible periods of coverage.	N30 - Recipient ineligible for this service.	Check DOS on ECF. If DOS is prior to 07/01/04 and service was not directly related to emergency institutional services, service is non-covered. **UB CLAIM:** Only inpatient claims will be reimbursed.
062	HEALTHY CONNECTIONS KIDS (HCK) - RECIPIENT in HMO Plan/ Service Covered by HMO	24 - Payment for charges adjusted. Charges are covered under a capitation agreement/managed care plan.		This recipient is in the Healthy Connections Kids (HCK) Program and enrolled with an HMO. These services are covered by the HMO. Bill the HMO and discard the edit correction form. Contact the Managed Care Department at 898-4614 if additional assistance is needed.
065	PHYSICIAN ASST SRVC/RECIPIENT NOT QMB/CLAIM NOT CROSSOVER	185 - Rendering provider is not eligible to perform the service billed.	N30 - Recipient ineligible for this service	Contact your program area representative.
101	INTERIM BILL	135 - Claim denied. Interim bills cannot be processed.		Verify the bill type in field 4 and the discharge status in field 17. Medicaid does not process interim bills. Please do not file a claim until the recipient is discharged from acute care.
102	INVALID DIAGNOSIS/ PROCEDURE CODE	16 – Claim/service lacks information which is needed for adjudication.	M67 - Incomplete/invalid other procedure code(s) and/or date(s). M76 - Incomplete/invalid patient's diagnosis(es) and condition(s).	Check the most current edition of the ICD for the correct code. This could be either a diagnosis or a surgical procedure code. If the code on your ECF is incorrect, mark through the code, write in the correct code, and resubmit.
103	SEX/DIAGNOSIS/ PROCEDURE INCONSISTENT	7 - The procedure/revenue code is inconsistent with the patient's gender. 10 - The diagnosis is inconsistent with the patient's gender.		Verify the recipient's Medicaid ID number. Make the appropriate correction if applicable. Compare the sex on your records with the sex listed on the first line of the body of your ECF. If there is a discrepancy, contact the county Medicaid office and ask them to correct sex on file for this recipient. After the county Medicaid office has made the correction, send the ECF to your program representative. If the sex is the same on your file and the ECF, check the current ICD for codes which are sex-specific. Verify that this is the correct code. If all of the information is correct, contact your program representative.

APPENDIX 1   EDIT CODES, CARCS/RARCS, AND RESOLUTIONS

Edit Code	Description	CARC	RARC	Resolution
104	AGE/DIAGNOSIS/ PROCEDURE INCONSISTENT	6 - The procedure/revenue code is inconsistent with patient's age. 9 - The diagnosis is inconsistent with the patient's age.		Verify the recipient's Medicaid ID number. Make the appropriate correction, if applicable. Compare the date of birth on your records with the date of birth listed on the first line of the body of your ECF. If there is a discrepancy, contact the county Medicaid office and ask them to correct the date of birth on file for this recipient. After the county Medicaid office has made the correction, send the ECF to your program representative. If the date of birth is the same on your file and the ECF, check the current ICD for codes that are age-specific. Verify that this is the correct code. If so, attach documentation that confirms the code on the ECF and send to your program representative.
105	PRINCIPAL DIAG NOT JUSTIFICATION FOR ADM	A8 - Claim denied; ungroupable DRG.		Check diagnosis codes in the most current edition of the ICD for codes marked with a Q (Questionable Admission). Verify that the diagnosis codes are listed in the correct order, and that all codes have been used. If the code listed is one marked with a Q, Medicaid does not allow this code as a principal diagnosis. Mark through the code and write the correct code
106	MANIFESTATION CODE UNACCEPT AS PRIN DIAG	A8 - Claim denied; ungroupable DRG.		Manifestation codes describe the manifestation of an underlying disease, not the disease itself, and should not be used as a principal diagnosis. If a manifestation code is listed as the principal diagnosis, mark through the code and write the correct code.
107	CROSSWALK TO DETECT MULTIPLE DRG'S	A1 – Claim/service denied.	N208 – Missing/incomplete/ invalid DRG code	Contact your program representative.
108	E-CODE NOT ACCEPTABLE AS PRINCIPAL DIAG	A8 - Claim denied; ungroupable DRG.		E-codes describe the circumstance that caused an injury, not the nature of the injury, and should not be used as a principal diagnosis. If an E-code is listed as the principal diagnosis, mark through the code and write the correct code. E-codes should be used in the designated E-code field (field 72)
109	DIAG/PROC HAS INVALID 4TH OR 5TH DIGIT	146 – Payment denied because the diagnosis was invalid for the date(s) of service reported.	MA66 - Incomplete/invalid principal procedure code and/or date. M64 - Incomplete/invalid other diagnosis code. M67 - Incomplete/invalid other procedure code(s) and/or date.	Medicaid requires a complete diagnosis or procedure code as specified in the current edition of ICD 9. Mark through the existing diagnosis or procedure code and write in the entire correct code. ICD updates are edited effective with the date of discharge.
112	MEDICAID NON-COVER PROC-37.5, 50.51, 50.59	96 - Non-covered charge(s).	N431 - Service is not covered with this procedure.	Provider is not authorized to bill for these procedures, as Medicaid does not cover them.

APPENDIX 1   EDIT CODES, CARCS/RARCS, AND RESOLUTIONS

Edit Code	Description	CARC	RARC	Resolution
113	SELECTED V-CODE NOT ACCEPT AS PRIN DIAG	96 - Non-covered charge(s).	MA63 - Incomplete/invalid principal diagnosis code.	Not all V-Codes can be used as the principal diagnosis in field 67. Check the most current edition of the ICD for an acceptable code. Mark through the existing diagnosis code and write in the correct code.
114	INVALID AGE - NOT BETWEEN 0 AND 124	6 - The procedure/revenue code is inconsistent with the patient's age.		Contact your county Medicaid Eligibility office to correct the date of birth on the recipient's file. After the county Medicaid Eligibility office has made the correction, send the ECF to your program representative.
115	INVALID SEX - MUST BE MALE OR FEMALE	16 – Claim/service lacks information which is needed for adjudication.	MA39 - Incomplete/invalid patient's sex.	Contact your county Medicaid Eligibility office to correct the sex on the recipient's file. After the county Medicaid Eligibility office has made the correction, send the ECF to your program representative.
116	INVALID PAT STATUS-MUST BE 01-07, 20, 30	16 – Claim/service lacks information which is needed for adjudication.	MA43 - Incomplete/invalid patient status.	Check the most current edition of the NUBC manual for a list and descriptions of valid discharge status codes for field 17. If the discharge status code on your ECF is not valid for Medicaid billing, mark through the code and write in the correct code.
117	DRG 469 - PRIN DIAG NOT EXACT ENOUGH	16 – Claim/service lacks information which is needed for adjudication.	M81 - Patient's diagnosis in a narrative form is not provided on an attachment or diagnosis code(s) is truncated, incorrect or missing; you are required to code to the highest level of specificity.	Verify the diagnoses and procedure codes on your claim are correct. If not, mark through the incorrect codes and write in the correct code. If information on the claim is correct, consult with your medical records department, as this is a non-covered DRG.
118	DRG 470 - PRINCIPAL DIAGNOSIS INVALID	16 – Claim/service lacks information which is needed for adjudication.	MA63 - Incomplete/invalid principal diagnosis code.	Resolution is the same as for edit code 117.
119	INVALID PRINCIPAL DIAGNOSIS	16 – Claim/service lacks information which is needed for adjudication.	MA63 - Incomplete/invalid principal diagnosis code.	Verify the diagnosis in the current ICD-9 manual. Make corrections and resubmit.
120	CLM DATA INADEQUATE CRITERIA FOR ANY DRG	A8 - Claim Denied ungroupable DRG.		Verify data with the medical records department. Make corrections and resubmit.
121	INVALID AGE	6 - Procedure/revenue code inconsistent with age. 9 - Diagnosis inconsistent with age.		Contact your county Medicaid Eligibility office to correct the date of birth on the recipient's file. After the county Medicaid Eligibility office has made the correction, send the ECF to your program representative.

APPENDIX 1   EDIT CODES, CARCS/RARCS, AND RESOLUTIONS

Edit Code	Description	CARC	RARC	Resolution
122	INVALID SEX	16 – Claim/service lacks information which is needed for adjudication.	MA39 - Incomplete/invalid patient's sex.	Contact your county Medicaid Eligibility office to correct the sex on the recipient's file. After the county Medicaid Eligibility office has made the correction, send the ECF to your program representative.
123	INVALID DISCHARGE STATUS	16 – Claim/service lacks information which is needed for adjudication.	N50 - Discharge information missing/incomplete/incorrect/ invalid.	Check the most current edition of the NUBC manual for a list and descriptions of valid discharge status codes for field 17. If the discharge status code on your ECF is not valid for Medicaid billing, mark through the code and write in the correct code.
125	PPS PROVIDER RECORD NOT ON FILE	38 - Services not provided or authorized by designated (network) providers. B7 - This provider was not certified/eligible for this procedure/service on this date.		Contact your program representative.
127	PPS STATEWIDE RECORD NOT ON FILE	B7 - This provider was not certified/eligible to be paid for this procedure/service on this date of service.		Contact your program representative.
128	DRG PRICING RECORD NOT ON FILE	A8 - Claim Denied ungroupable DRG.		Verify the diagnoses and procedure codes on your claim are correct. If not, mark through the incorrect codes and write in the correct code. If information on claims is correct, consult with your medical records department, as this DRG is not currently priced by Medicaid. Contact your program representative.

APPENDIX 1   EDIT CODES, CARCS/RARCS, AND RESOLUTIONS

Edit Code	Description	CARC	RARC	Resolution
150	TPL COVER VERIFIED/FILING NOT IND ON CLM	22 – Payment adjusted because this care may be covered by another payer per coordination of benefits.	MA92 - Our records indicate that there is insurance primary to ours; however, you did not complete or enter accurately the required information.	Please see INSURANCE POLICY INFORMATION on the ECF (to the right of the Medicaid Claims Receipt Address) for the three-digit carrier code that identifies the insurance company, as well as the policy number and the policyholder's name. Identify the insurance company by referencing the numeric carrier code list in this manual. File the claim(s) with the primary insurance before re-filing to Medicaid. If the insurance company that has been billed is the one that appears on the ECF, enter the carrier code in field 24 (must exactly match the carrier code(s) under INSURANCE POLICY INFORMATION). Enter the policy number in field 25 (must exactly match the policy number(s) under INSURANCE POLICY INFORMATION). If payment is made, enter the total amount(s) paid in fields 26 and 28. Adjust the balance due in field 29. If payment is denied (*i.e.,* applied to the deductible, policy lapsed, etc.) by the other insurance company, put a "1" (denial indicator) in field 4. Attach a copy of the EOB from each insurance company to the ECF and resubmit to the address on the form. If the carrier that has been billed is not the insurance for which the claim received edit 150, the provider must file with the insurance carrier that is indicated in MMIS. **UB CLAIM:** Enter the carrier code in field 50. Enter the policy number in field 60. If payment is made, enter the amount paid in field 54. If payment is denied, enter 0.00 in field 54 and also enter code 24 and the date of denial in the Occurrence Code fields 31-34 A and B.
151	MULTIPLE INS POL/NOT ALL FILED-CALL TPL	22 – Payment adjusted because this care may be covered by another payer per coordination of benefits.	MA64 - Our records indicate that we should be the third payer for this claim. We cannot process this claim until we have received payment information from the primary and secondary payers.	Eliminate any duplicate primary insurance policy entries on the CMS-1500, ensuring that blocks 9 and 11 contain unique information, one carrier per block. Medicaid coverage should not be entered in either primary block. If there is no duplicate information, refer to the INSURANCE POLICY INFORMATION section on the ECF, and file the claim(s) with each insurance company listed before re-filing to Medicaid. Enter all insurance results on the ECF. Documentation must show that each policy has been billed, and that proper coordination of benefits has been followed, *e.g.,* bill primary carrier first, then bill second carrier for the difference. If there are three or more separate third-party payers, the claim must be processed by the Third-Party Liability division of DHHS. Submit all EOBs (three or more) to Third-Party Liability.
155	POSS NOT POSITIVE INS MATCH/OTHER ERRORS	22 – Payment adjusted because this care may be covered by another payer per coordination of benefits.	MA92 - Our records indicate that there is insurance primary to ours; however, you did not complete or enter accurately the required information.	Bill the primary insurer(s) according to the resolution instructions for edit code 150.

APPENDIX 1   EDIT CODES, CARCS/RARCS, AND RESOLUTIONS

Edit Code	Description	CARC	RARC	Resolution
156	TPL VERIFIED/FILING NOT INDICATED ON CLM	22 – Payment adjusted because this care may be covered by another payer per coordination of benefits.	MA08 - You should also submit this claim to the patient's other insurer for potential payment of supplemental benefits. We did not forward the claim information as the supplemental coverage is not with a Medigap plan or you do not participate in Medicare.	File a claim with the insurance company listed under INSURANCE POLICY INFORMATION on the ECF. (Refer to the carrier code list in the provider manual.) If the insurance company denies payment or makes a partial payment, attach a copy of the explanation of benefits and resubmit. If the insurance carrier pays the claim in full, discard the ECF.
170	LAB PROC BILLED/NO CLIA # ON FILE	B7 - This provider was not certified/eligible to be paid for this procedure/service on this date of service.		Submit a copy of your CLIA certification to program representative.
171	NON-WAIVER PROC/PROV HAS CERT OF WAIVER	B7 - This provider was not certified/eligible to be paid for this procedure/service on this date of service.		Our records indicate that your CLIA certificate or waiver allows Medicaid reimbursement for waivered procedures only. Lab services billed are not waivered procedures. If your CLIA certification has changed, attach a copy of your updated CLIA letter from CMS to your ECF. If your certificate has not been updated, Medicaid will not reimburse for the service.
172	D.O.S. NONCOVERED ON CLIA CERT DATE	B7 - This provider was not certified/eligible to be paid for this procedure/service on this date of service.		Medicaid will not reimburse for services outside CLIA certification dates. If your CLIA certification has been renewed, attach a copy of your updated CLIA letter from CMS to your ECF. Contact your lab director or CMS for current CLIA certificate information.
174	NON-PPMP PROC/PROV HAS PPMP CERT	B7 - This provider was not certified/eligible to be paid for this procedure/service on this date of service.		Submit a copy of your updated CLIA Certification to your program representative.
201	MISSING RECIPIENT ID NO	31 - Claim denied, as patient cannot be identified as our insured.		**CMS-1500 CLAIM:** Enter the patient's 10-digit Medicaid ID# in field 2 on the ECF. **UB CLAIM:** Enter the patient's 10-digit Medicaid ID# in field 60 on the ECF. **All other provider/claim types**: Contact your program representative.
202	MISSING NATIONAL DRUG CODE (NDC)	16 – Claim/service lacks information which is needed for adjudication.	M119- Missing/incomplete/invalid/ deactivated/withdrawn National Drug Code (NDC).	Discard ECF. Enter NDC on new claim and re-submit. Contact your program representative for further assistance.

APPENDIX 1   EDIT CODES, CARCS/RARCS, AND RESOLUTIONS

Edit Code	Description	CARC	RARC	Resolution
205	MISSING NET CLAIM CHARGE	16 – Claim/service lacks information which is needed for adjudication.	M54 - Did not complete or enter the correct total charges for services rendered.	**CMS-1500 CLAIM:** Enter the balance due in field 29 of the ECF. Balance due (field 29) is equal to total charges (field 27) minus the amount received from insurance (field 28).
206	MISSING DATE OF SERVICE	16 – Claim/service lacks information which is needed for adjudication.	M59 - Incomplete/invalid "to" date(s) of service.	**CMS-1500 CLAIM:** Enter missing date of service in field 15 on the ECF. **UB CLAIM:** Enter missing date of service in field 45 on the ECF.
207	MISSING SERVICE CODE	16 – Claim/service lacks information which is needed for adjudication.	M51 – Missing/incomplete/invalid procedure codes (s)	**CMS-1500 CLAIM:** Enter missing procedure code in field 17 on the ECF.
208	NO LINES ON CLAIM	16 – Claim/service lacks information which is needed for adjudication.		Resubmit claim with billable services.
209	MISSING LINE ITEM SUBMITTED CHARGE	16 – Claim/service lacks information which is needed for adjudication.	M79 - Did not complete or enter the appropriate charge for each listed service.	**CMS-1500 CLAIM:** Enter missing charges in field 20 on the ECF. **UB CLAIM:** Enter missing charges in field 47 on the ECF.
210	MISSING TAXONOMY CODE	16 - Claim/service lacks information which is needed for adjudication.	N94 - Claim/Service denied because a more specific taxonomy code is required for adjudication.	Enter taxonomy code on the ECF. Taxonomy codes are required when an NPI is shared by multiple legacy provider numbers. Contact your program representative if you have additional questions.
213	LINE ITEM MILES OF SERVICE MISSING	16 – Claim/service lacks information which is needed for adjudication.	M22 - Claim lacks the number of miles traveled.	Enter the number of miles in field 22 on the ECF and resubmit.
219	PRESENT ON ADMISSION (POA) INDICATOR IS MISSING, DIAGNOSIS IS NOT EXEMPT	A1-Claim/Service denied.	N434 - Missing/Incomplete/Invalid Present on Admission indicator.	Contact your program representative.
225	FUND CODE NOT ASSIGNED	16 – Claim/service lacks information which is needed for adjudication.	M56 – Missing/incomplete/invalid payer identifier	Contact your program area representative.
227	MISSING LEVEL OF CARE	16 – Claim/service lacks information which is needed for adjudication.		Contact your program representative.
233	PRIMARY DIAGNOSIS CODE IS MISSING	16 – Claim/service lacks information which is needed for adjudication.	MA63 - Incomplete/invalid principal diagnosis code.	Enter the primary diagnosis code in field 8 on the ECF from the current edition of the ICD-9, Volume I.

APPENDIX 1   EDIT CODES, CARCS/RARCS, AND RESOLUTIONS

Edit Code	Description	CARC	RARC	Resolution
234	PLACE OF SERVICE MISSING	16 – Claim/service lacks information which is needed for adjudication.	M77-Missing/incomplete/invalid place of service	**CMS-1500 CLAIM:** Enter the place of service in field 16 on the ECF.
239	MISSING LINE NET CHARGE	16 – Claim/service lacks information which is needed for adjudication.	M79-Missing/incomplete/invalid charge	Contact your program representative.
243	ADMISSION DATE/START OF CARE MISSING	16 – Claim/service lacks information which is needed for adjudication.	MA40 - Incomplete/invalid admission date.	Enter the admission/start of care date in field 12.
244	PRINCIPAL DIAGNOSIS CODE MISSING	16 – Claim/service lacks information which is needed for adjudication.	MA63 - Incomplete/invalid principal diagnosis code.	Enter the principal diagnosis code in field 67.
245	TYPE OF BILL MISSING	16 – Claim/service lacks information which is needed for adjudication.	MA30 - Incomplete/invalid type of bill.	Refer to the most current edition of the NUBC manual for valid type of bill. Enter a valid Medicaid bill type code in field 4.
246	FIRST DATE OF SERVICE MISSING	16 – Claim/service lacks information which is needed for adjudication.	M52 - Incomplete/invalid "from" date(s) of service.	**UB CLAIM**: Enter the first date of service in field 6. **All other provider/claim types**: Contact your program representative.
247	MISSING LAST DATE OF SERVICE	16 – Claim/service lacks information which is needed for adjudication.	M59 - Incomplete/invalid "to" date(s) of service.	Enter the last date of service in field 6.
248	TYPE OF ADMISSION MISSING	16 – Claim/service lacks information which is needed for adjudication.	MA41 - Incomplete/invalid type of admission.	Refer to the most current edition of the NUBC manual for valid types of admissions. Enter a valid Medicaid type of admission code in field 14.
249	TOTAL CLAIM CHARGE MISSING	16 – Claim/service lacks information which is needed for adjudication.	M54 - Did not complete or enter the correct total charges for services rendered.	Enter revenue code 001 on the total charges line in field 42. This revenue code must be listed as the last field.
252	PATIENT STATUS MISSING	16 – Claim/service lacks information which is needed for adjudication.	MA43 - Incomplete/invalid patient status.	Refer to the most current edition of the NUBC manual for patient status. Enter the valid Medicaid patient status code in field 17.
253	SOURCE OF ADMISSION MISSING	16 – Claim/service lacks information which is needed for adjudication.	MA42 - Incomplete/invalid source of admission.	Refer to the most current edition of the NUBC Manual for source of admission. Enter a valid Medicaid source of admission code in field 15.
263	MISSING TOTAL DAYS	16 – Claim/service lacks information which is needed for adjudication.	M53 – Missing/incomplete/invalid days or units of service	Contact your program representative.

APPENDIX 1   EDIT CODES, CARCS/RARCS, AND RESOLUTIONS

Edit Code	Description	CARC	RARC	Resolution
281	PROCEDURE CODE MODIFIER MISSING	4 - The procedure code is inconsistent with the modifier used, or a required modifier is missing.		Enter modifier in field 18 of the line that received the edit code.
300	UB82 FORM NO LONGER ACCEPTED	16 – Claim/service lacks information which is needed for adjudication.	N34 - Incorrect claim for this service.	Resubmit claim on a UB-92 claim form.
301	INVALID NATIONAL DRUG CODE (NDC)	16 - Claim/service lacks information which is needed for adjudication.	M119 – Missing / incomplete/invalid/ deactivated/withdrawn National Drug Code (NDC).	Contact your program representative for further assistance.
304	TOTAL CLAIM CHARGE NOT NUMERIC	16 – Claim/service lacks information which is needed for adjudication.	M54 - Did not complete or enter the correct total charges for services rendered.	**CMS-1500 CLAIM:** Enter the correct numeric amount in field 27.
305	INVALID TAXONOMY CODE	16 - Claim/service lacks information that is needed for adjudication.	N94 - Claim/Service denied because a more specific taxonomy code is required for adjudication.	Taxonomy code must be valid. Valid codes are found at http://www.wpc-edi.com/codes/taxonomy Contact your program representative if you have additional questions.
308	INVALID PROCEDURE CODE MODIFIER	4 - The procedure code is inconsistent with the modifier used or a required modifier is missing.	N13 - Payment based on professional/technical component modifier(s).	Enter correct modifier in field 18 on the ECF and resubmit.
309	INVALID LINE ITEM MILES OF SERVICE	16 – Claim/service lacks information which is needed for adjudication.	M22 - Claim lacks the number of miles traveled.	Enter the correct number of miles in field 22 on the ECF and resubmit.
310	INVALID PLACE OF SERVICE	16 – Claim/service lacks information which is needed for adjudication.	M77 - Incomplete/invalid place of service(s).	**CMS-1500 CLAIM:** Medicaid requires the numeric coding for place of service. Enter the appropriate place of service code in field 16.
311	INVALID LINE ITEM SUBMITTED CHARGE	16 – Claim/service lacks information which is needed for adjudication.	M79 - Did not complete or enter the appropriate charge for each listed service.	**CMS-1500 CLAIM:** Enter the correct charge in field 20. **UB CLAIM:** Enter the correct charge in field 47.
312	MODIFIER NON-COVERED BY MEDICAID	4 - The procedure code is inconsistent with the modifier used, or a required modifier is missing.		A modifier not accepted by Medicaid has been filed and entered in field 18 on the ECF. Enter the correct modifier in field 18.

APPENDIX 1   EDIT CODES, CARCS/RARCS, AND RESOLUTIONS

Edit Code	Description	CARC	RARC	Resolution
316	THIRD PARTY CODE INVALID	16 – Claim/service lacks information which is needed for adjudication.	MA92 - Our records indicate that there is insurance primary to ours; however, you did not complete or enter accurately the required information.	**CMS-1500 CLAIM:** Incorrect third party code was used in field 4 on the ECF. Correct coding would be "1" for denial or "6" for crime victim. Enter the correct code in field 4. If a third party payer is not involved with this claim, mark through the character in field 4.
317	INVALID INJURY CODE	16 – Claim/service lacks information which is needed for adjudication.		Incorrect injury code was used. Correct coding would be "2" for work related accident, "4" for automobile accident, or "6" for other accident. Please enter the correct injury code on ECF and resubmit.
318	INVALID EMERGENCY INDICATOR / EPSDT REFERRAL CODE	16 – Claim/service lacks information that is needed for adjudication.		Verify that the emergency indicator / EPSDT referral code on the ECF was billed correctly. If incorrect, make the appropriate correction. Contact your program representative if you need additional assistance.
321	NET CLAIM CHARGE NOT NUMERIC	16 – Claim/service lacks information which is needed for adjudication.	M49 - Incomplete/invalid value code(s) and/or amount(s).	**CMS-1500 CLAIM:** Enter the numeric claim charge in field 27 of the ECF and resubmit.
322	INVALID AMT RECEIVED FROM OTHER RESOURCE	16 – Claim/service lacks information which is needed for adjudication.	M49 - Incomplete/invalid value code(s) and/or amount(s).	Enter a valid number amount in "amount other sources".
323	INVALID LINE ITEM UNITS OF SERVICE	16 – Claim/service lacks information which is needed for adjudication.	M53 - Did not complete or enter the appropriate number (one or more) of days or unit(s) of service.	**CMS-1500 CLAIM:** Enter the correct numeric units in field 22. **UB CLAIM:** Enter the correct numeric units in field 46.
330	INVALID LINE ITEM DATE OF SERVICE	16 – Claim/service lacks information which is needed for adjudication.	M52 - Incomplete/invalid "from" date(s) of service.	**CMS-1500 CLAIM:** Enter the correct date of service in field 15. Make sure that the correct number of days is being billed for the billing month.
339	PRESENT ON ADMISSION (POA) INDICATOR IS INVALID	A1- Claim/Service denied.	N434 - Missing/Incomplete/Invalid Present on Admission indicator.	Contact your program representative.
354	TOOTH NUMBER NOT VALID LETTER OR NUMBER	16 – Claim/service lacks information which is needed for adjudication.	N39 - Procedure code is not compatible with tooth number/letter.	Enter the valid tooth number or letter in field 15 on the ECF. Verify tooth number or letter with procedure code.
355	TOOTH SURFACE CODE INVALID	16 – Claim/service lacks information which is needed for adjudication.	N75 - Missing or invalid tooth surface information.	Enter the correct tooth surface code in field 16 on the ECF.

APPENDIX 1   EDIT CODES, CARCS/RARCS, AND RESOLUTIONS

Edit Code	Description	CARC	RARC	Resolution
356	IMMUNIZATION AND ADMINISTRATION CODES MUST BE INCLUDED ON CLAIM	B5 – Coverage/program guidelines were not met or were exceeded.	N349 – The administration method and drug must be reported to adjudicate this service.	Contact your program area representative for further assistance.
357	MAXIMUM OF THREE ADMINISTRATION UNITS CAN BE BILLED PER DATE OF SERVICE	B5 – Coverage/program guidelines were not met or were exceeded.	N362 – The number of days or units of service exceeds our acceptable maximum.	Contact your program area representative for further assistance.
358	SECONDARY ADMINISTRATION CPT CODE NOT ALLOWED PRIOR TO PRIMARY CODE	B15 – This service/procedure requires that a qualifying service/procedure be received and covered. The qualifying other service/procedure has not been received/adjudicated.	N349 – The administration method and drug must be reported to adjudicate this service.	Contact your program area representative for further assistance.
367	ADMISSION DATE/START OF CARE INVALID	16 – Claim/service lacks information which is needed for adjudication.	MA40 - Incomplete/invalid admission date.	Draw a line through the admission/start of care date in field 12, and write the correct date. Date must be six digits and numeric.
368	TYPE OF ADMISSION NOT VALID	16 – Claim/service lacks information which is needed for adjudication.	MA41 - Incomplete/invalid type of admission.	Refer to the most current edition of the NUBC manual for valid type of admission. Enter a valid Medicaid type of admission code in field 14.
369	MONTHLY INCURRED EXPENSES MUST BE VALID	16 – Claim/service lacks information which is needed for adjudication.		Contact your program representative.
370	SOURCE OF ADMISSION INVALID	16 – Claim/service lacks information which is needed for adjudication.	MA42 - Incomplete/invalid source of admission.	Refer to the most current edition of the NUBC manual for valid source of admission. Enter a valid Medicaid source of admission code in field 15.
373	PRINCIPAL SURG PROCEDURE DATE INVALID	16 – Claim/service lacks information which is needed for adjudication.	MA66 - Incomplete/invalid principal procedure code and/ or date.	Draw a line through the invalid date in field 74 and enter correct date. Date must be six digits and numeric.
375	OTHER SURGICAL PROCEDURE DATE INVALID	16 – Claim/service lacks information which is needed for adjudication.	M67 - Incomplete/invalid other procedure code(s) and/ or date(s).	Draw a line through the invalid date in field 74, A - E, and enter correct date. Date must be six digits and numeric.

APPENDIX 1   EDIT CODES, CARCS/RARCS, AND RESOLUTIONS

Edit Code	Description	CARC	RARC	Resolution
376	TYPE OF BILL NOT VALID FOR MEDICAID	16 – Claim/service lacks information which is needed for adjudication.	MA30 - Incomplete/invalid type of bill.	Refer to the most current edition of the NUBC manual for valid type of bill. Enter a valid Medicaid type of bill in field 4.
377	FIRST DATE OF SERVICE INVALID	16 – Claim/service lacks information which is needed for adjudication.	M52 – Missing/incomplete/invalid "from" date(s) of service	**UB CLAIM:** Enter the correct date of service in field 6. **All other provider/claim types**: Contact your program representative.
378	LAST DATE OF SERVICE INVALID	16 – Claim/service lacks information which is needed for adjudication.	M59 - Incomplete/invalid "to" date(s) of service.	Draw a line through the invalid date in field 6, and enter the correct "to" date. Date must be six digits and numeric.
379	VALUE CODE INVALID	16 – Claim/service lacks information which is needed for adjudication.	M49 - Incomplete/invalid value code(s) and/or amount(s).	Refer to the most current edition of the NUBC manual for valid value codes. Draw a line through the invalid code in fields 39 - 41 A - D, and enter the correct code.
380	VALUE AMOUNT INVALID	16 – Claim/service lacks information which is needed for adjudication.	M49 - Incomplete/invalid value code(s) and/or amount(s).	Draw a line through the amount in fields 39 - 41 A - D, and enter the correct numeric amount.
381	OCCURRENCE DATE INVALID	16 – Claim/service lacks information which is needed for adjudication.	M45 - Incomplete/invalid occurrence codes and dates.	Draw a line through the incorrect date in fields 31 - 34 A - B, and enter the correct date. Dates must be six digits and numeric.
382	PATIENT STATUS NOT VALID FOR MEDICAID	16 – Claim/service lacks information which is needed for adjudication.	MA43 - Incomplete/invalid patient status.	Refer to the most current edition of the NUBC manual for valid status codes. Enter a valid Medicaid patient status code in field 17.
383	OCCURR.CODE, INCL. SPAN CODES, INVALID	16 – Claim/service lacks information which is needed for adjudication.	M45 - Incomplete/invalid occurrence codes and dates. M46 - Incomplete/invalid occurrence span code and dates.	Refer to the most current edition of the NUBC manual for valid occurrence codes. Enter a valid Medicaid occurrence code in fields 31 – 34, A – B and in fields 35-36, A - B.
384	CONDITION CODE INVALID	16 – Claim/service lacks information which is needed for adjudication.	M44 - Incomplete/invalid condition code.	Refer to the most current edition of the NUBC manual for valid condition codes. Enter a valid Medicaid condition code in fields 18 – 28.
385	TOTAL CHARGE INVALID	16 – Claim/service lacks information which is needed for adjudication.	M54 - Did not complete or enter the correct total charges for services rendered.	Total charge must be numeric. Draw a line through the invalid total, and enter the correct numeric total charge.
386	QIO APPROVAL INDICATOR INVALID	15 - The authorization number is missing, invalid, or does not apply to the billed services or provider.	N229 - Incomplete/invalid contract indicator.	

APPENDIX 1   EDIT CODES, CARCS/RARCS, AND RESOLUTIONS

Edit Code	Description	CARC	RARC	Resolution
387	NON COVERED CHARGE INVALID	96 - Non-covered charge(s).		Charges must be numeric. Draw a line through the invalid charge in field 48, and enter the correct numeric charge.
390	TPL PAYMENT AMT NOT NUMERIC	16 – Claim/service lacks information which is needed for adjudication.	M49 - Incomplete/invalid value code(s) and/or amount(s).	Enter numeric payment from all primary insurance companies in field 26 or enter 0.00 if no payment was received. If the claim was denied by the other insurance company, put a "1" (denial indicator) in field 4. If no third party insurance was involved, delete information entered in field 26 by drawing a red line through it.
391	PATIENT PRIOR PAYMENT AMT NOT NUMERIC	16 – Claim/service lacks information which is needed for adjudication.	M49 - Incomplete/invalid value code(s) and/or amount(s).	
394	OCCURRENCE SPAN CODES"FROM"DATE INVALID	16 – Claim/service lacks information which is needed for adjudication.	M46 - Incomplete/invalid occurrence span codes and dates.	Dates must be six digits and numeric. Draw a line through the invalid date in field 35 – 36 A - B, and enter the correct date.
395	OCCURRENCE SPAN CODES"THRU"DATE INVALID	16 – Claim/service lacks information which is needed for adjudication.	M46 - Incomplete/invalid occurrence span codes and dates.	Date must be six digits and numeric. Draw a line through the invalid date in field 35 - 36 A - B and enter the correct date.
400	TPL CARR and POLICY # MUST BOTH BE PRESENT	22 – Payment adjusted because this care may be covered by another payer per coordination of benefits.	MA92 - Our records indicate that there is insurance primary to ours; however, you did not complete or enter accurately the required information.	Make sure a valid carrier code is entered in field 24 and a valid policy number is entered in field 25. Follow the 150 resolution and indicate whether the primary insurance denied or paid the claim. **UB CLAIM:** Enter a valid carrier code in field 50 and a valid policy number in field 60.
401	AMT IN OTHER SOURCES/NO TPL CARRIER CODE	22 – Payment adjusted because this care may be covered by another payer per coordination of benefits.	MA92 - Our records indicate that there is insurance primary to ours; however, you did not complete or enter accurately the required information.	**CMS-1500 CLAIM:** Complete fields 24, 25, and 26 (carrier code, policy number, amount paid). If the insurance company denied payment, put the denial indicator "1" in field 4. **Notes:** If there is no third party involved, be sure all third party fields (4, 24, 25, 26, 28) are deleted of information by marking through in red. If there are more than two other insurance companies that have paid, enter the total combined amounts paid by all insurance companies in field 28. The total combined amounts should be equal to field 26.
402	DEDUCTIBLE EXCEEDS CALENDAR YEAR LIMIT			Refer to the EOMB for the deductible amount (including blood deductible). If the amount entered is incorrect, change the amount. If it agrees, attach the EOMB/Medicare electronic printout to the ECF and return to your program representative. Do not add professional fees in the deductible amount. Professional fees should be filed separately on a CMS-1500 form under the hospital-based physician provider number.

APPENDIX 1   EDIT CODES, CARCS/RARCS, AND RESOLUTIONS

Edit Code	Description	CARC	RARC	Resolution
403	INCURRED EXPENSES NOT ALLOWED	45- Charge exceeds fee schedule/maximum allowable or contracted/legislated fee arrangement.		Contact your program representative.
411	ANESTHESIA PROC REQUIRES ANES. MODIFIER	4 - The procedure code is inconsistent with the modifier used, or a required modifier is missing.		Refer to the current list of anesthesia modifiers found in section 2 and enter the correct modifier in field 18 on the ECF.
412	SURG PROC NOT VALID W/ANES. MODIFIER	4 - The procedure code is inconsistent with the modifier used, or a required modifier is missing.		Enter the appropriate anesthesia procedure when a anesthesiologist administers anesthesia during a surgical procedure.
460	PROCEDURE CODE / INVOICE TYPE INCONSISTENT	125 - Payment adjusted due to a submission/billing error(s). Additional information is supplied using the remittance advice remark codes whenever appropriate.	MA30 - Missing/incomplete/ invalid type of bill.	Oral & Maxillofacial Surgeons must file CPT procedure codes on the CMS-1500 and CDT procedure codes on the ADA Claim Form.
463	INVALID TOTAL DAYS	16 – Claim/service lacks information which is needed for adjudication.	M59 - Incomplete/invalid "to" date(s) service.	Contact your program representative.
468	CARRIER CODE 619 (MEDICAID) LISTED TWICE	16 – Claim/service lacks information which is needed for adjudication.	M56 - Incomplete/invalid payer identification.	Draw a line through the carrier code 619 which appears on either the first or second "other payer" line in field 50 on your ECF. Do not draw a line through the 619 after "Medicaid Carrier ID."
469	INVALID LINE NET CHARGE	16 – Claim/service lacks information which is needed for adjudication.	M49 - Incomplete/invalid value code(s) and/or amount(s).	Contact your program representative.
501	INVALID DATE ON REVENUE LINE	16 – Claim/service lacks information which is needed for adjudication.		Enter the correct date in field 45 on the ECF.
502	DOS AFTER THE ENTRY DATE/ JULIAN DATE	110 - Billing date predates service date.		**CMS-1500 CLAIM:** Verify the date of service in field 15 on ECF. Correct if not accurate. If date of service is correct, a new claim will need to be submitted. Cannot submit a claim prior to the date of service.

APPENDIX 1   EDIT CODES, CARCS/RARCS, AND RESOLUTIONS

Edit Code	Description	CARC	RARC	Resolution
503	INCORRECT DIAGNOSIS (REASON) CODE	16 – Claim/service lacks information which is needed for adjudication.	M76 - Incomplete/invalid patient's diagnosis(es) and condition(s).	Verify diagnosis code in the ICD coding manual and resubmit ECF.
504	PROVIDER TYPE AND INVOICE INCONSISTENT	170 – Payment is denied when performed/billed by this type of provider.	N34-Incorrect claim form/format for this service	Provider has filed the wrong claim form. Please contact your program representative for information on claims filing.
505	MISSING DATE ON REVENUE LINE	16 – Claim/service lacks information which is needed for adjudication.		Enter the date in field 45 on the ECF.
506	PANEL CODE and REVENUE CODE BILLED	16 – Claim/service lacks information which is needed for adjudication.	M15 - Separately billed services/tests have been bundled as they are considered components of the same procedure. Separate payment is now allowed.	**UB CLAIM:** Individual panel code and procedure codes included in the panel cannot be billed in combination on the claim for the same dates of service. Contact your program representative.
507	MANUAL PRICING REQUIRED	16 – Claim/service lacks information which is needed for adjudication.	N45-Payment based on authorized amount	Resubmit ECF with required documentation. Please refer to the appropriate section in your provider manual. Contact your program representative for additional information.
508	NO LINE ITEM RECORD	16 – Claim/service lacks information which is needed for adjudication.		**CMS-1500 CLAIM:** Complete fields 15 – 22 on the ECF and resubmit. **UB CLAIM:** Resubmit the claim or enter something on the line indicated and resubmit the ECF.
509	DOS OVER 2 YRS XOVER/ EXT CARE CLM ONLY	29 - The time limit for filing has expired.		Claims for payment of Medicare cost sharing amounts must be received and entered into the claims processing system within two years from the date of service or date of discharge, or up to six months following the date of Medicare payment, whichever is later. Attach appropriate documentation (Medicare EOMB) to each ECF and resubmit. **NURSING HOME PROVIDERS:** Resubmit ECF and appropriate documentation to : MCCS Nursing Facility Claims Post Office Box 100112 Columbia, SC 29202. Refer to the timely filing guidelines in the appropriate section of your provider manual.

APPENDIX 1   EDIT CODES, CARCS/RARCS, AND RESOLUTIONS

Edit Code	Description	CARC	RARC	Resolution
510	DOS IS MORE THAN 1 YEAR OLD	29 - The time limit for filing has expired.		Claims/ECFs for retroactive eligibility must be received and entered into the claims processing system within six months of the beneficiary's eligibility being added to the Medicaid eligibility system AND be received within three years from the date of service or date of discharge (for hospital claims). If the above time frames are met, attach one of the following documents listed below with each claim or ECF and resubmit. 1) DHHS Form 945, which is a statement verifying the retroactive determination furnished by the eligibility worker, or 2) The computer generated Medicaid eligibility approval letter notifying the beneficiary that Medicaid benefits have been approved. This can be furnished by the beneficiary or the eligibility worker. (This is different from the Certificate of Creditable Coverage.) **For NURSING HOME PROVIDERS:** Resubmit ECF and appropriate documentation to: MCCS Nursing Facility Claims Post Office Box 100112 Columbia, SC 29202. Refer to the timely filing guidelines in the appropriate section of your provider manual.
513	INCONSISTENT MEDICARE CARRIER CODE	16 – Claim/service lacks information which is needed for adjudication.	M56 - Incomplete/invalid payer identification.	Enter the correct Medicare Part A or Part B carrier code and resubmit. Contact your program representative if further assistance is needed.
514	PROC RATE/MILE X MILES NOT=SUBMIT CHRG	16 – Claim/service lacks information which is needed for adjudication.	M79 - Did not complete or enter the appropriate charge for each listed service.	Contact your program representative.
515	AMBUL/ITP TRANS. MILEAGE LIMITATION	16 – Claim/service lacks information which is needed for adjudication.	M22-Missing/incomplete/invalid number of miles traveled.	Contact your program representative.
517	WAIVER SERVICE BILLED. RECIPIENT NOT IN A WAIVER.	141 - Claim adjustment because the claim spans eligible and ineligible periods of coverage.	N30 - Recipient ineligible for this service.	The claim was submitted for a waiver-specific procedure code, but the recipient was not a participant in a Medicaid waiver. Check for error in using incorrect procedure code. If the procedure code is incorrect, strike through the incorrect code and write in the correct code above. Check for correct recipient Medicaid number. If the recipient Medicaid number is incorrect, strike through the incorrect number and write in the correct Medicaid number above. If the recipient Medicaid number and procedure code are correct, contact your program representative.

APPENDIX 1   EDIT CODES, CARCS/RARCS, AND RESOLUTIONS

Edit Code	Description	CARC	RARC	Resolution
518	PROCEDURE CODE COMBINATION NON-COVERED OR INVALID	16 - Claim/service lacks information which is needed for adjudication.	N56 – Procedure code billed is not correct/valid for the services billed or the date of service billed.	Contact your Dental Program Manager at (803) 898-2568.
519	CMS REBATE TERM DATE HAS EXPIRED/ENDED	29 - The time limit for filing has expired.	N304 – Missing/incomplete /invalid dispensed date.	Contact your program representative for further assistance.
528	PRTF WAIVER RECIPIENT BUT NOT WAIVER SERVICE	A1 - Claim/Service denied.		Contact your program area representative.
529	REVENUE CODE BEING BILLED OVER 15 TIMES PER CLAIM	A1 – Claim/Service denied.		This edit code cannot be manually corrected. A new claim must be submitted. Contact your program area representative if further assistance is needed
533	DOS IS MORE THAN 3 YEARS OLD	29 – The time limit for filing has expired.		Claim exceeds timely filing limits and will not be considered for payment. Refer to the timely filing guidelines in the appropriate section of your provider manual.
534	PROVIDER/CCN DO NOT MATCH FOR ADJUSTMENT	16 – Claim/service lacks information which is needed for adjudication.	M47 –Incomplete/invalid internal or document control number.	Review the original claim and verify the provider number from that claim. Make sure that the correct original provider number is entered on the adjustment claim and resubmit the adjustment claim.
536	PROCEDURE-MODIFIER NOT COVERED ON DOS	A1 – Claim/Service denied.		Verify that the correct procedure code and modifier combination was entered in field 17 and 18 on ECF for the date of service. Make the appropriate correction to the procedure code in field 17 and/or the modifier in field 18.
537	PROC-MOD COMBINATION NON-COVERED/INVALID	4 - The procedure code is inconsistent with the modifier used, or a required modifier is missing.		Verify that the correct procedure code and modifier combination was entered in fields 17 and 18 on ECF for the date of service. Make the appropriate correction to the procedure code in field 17 and/or modifier in field 18.
538	PATIENT PAYMENT EXCEEDS MED NON-COVERED	23 - Payment adjusted because charges have been paid by another payer.		
539	MEDICAID NOT LISTED AS PAYER	31 - Claim denied as patient cannot be identified as our insured.		Enter Medicaid payer code 619 in field 50 A through C line which corresponds with the line on which you entered the Medicaid ID number field 60 A through C.

APPENDIX 1   EDIT CODES, CARCS/RARCS, AND RESOLUTIONS

Edit Code	Description	CARC	RARC	Resolution
540	ACCOM REVENUE CODE/OP CLAIM INCONSIST	16 – Claim/service lacks information which is needed for adjudication.	M56 - Incomplete/invalid payer identification.	Room accommodation revenue codes cannot be used on an outpatient claim. If the room accommodation revenue codes are correct, check the bill type (field 4) and the Health Plan ID (field 51).
541	MISSING LINE ITEM/REVENUE CODE	16 – Claim/service lacks information which is needed for adjudication.	M50 – Missing/incomplete/invalid revenue code (s)	The two digits before the edit code tell you on which line in field 42 the revenue code is missing. Enter the correct revenue code for that line.
542	BOTH OCCUR CODE and DATE NEC INC SPAN CODE	16 – Claim/service lacks information which is needed for adjudication.	M46 - Incomplete/invalid occurrence span codes and dates.	If you have entered an occurrence code in fields 31 through 36 A and B, an occurrence date must be entered. If you have entered an occurrence date in any of these fields, an occurrence code must also be entered.
543	VALUE CODE/AMOUNT MUST BOTH BE PRESENT	16 – Claim/service lacks information which is needed for adjudication.	M49 - Incomplete/invalid value code(s) and/or amount(s).	If you have entered a value code in fields 39 through 41 A - D, a value amount must also be entered. If you have entered a value amount in these fields, a value code must also be entered.
544	NURSING HOME CLAIMS SUBMITTED VIA 837	125 - Payment adjusted due to a submission/billing error(s). Additional information is supplied using the remittance advice remark codes whenever appropriate.		Contact your program representative.
545	NO PROCESSABLE LINES ON CLAIM	16 – Claim/service lacks information which is needed for adjudication.	N142-The original claim was denied. Resubmit a new claim, not a replacement claim.	All lines on ECF have been rejected or deleted. Discard the ECF and resubmit the claim.
546	SURGICAL PROCEDURE MUST BE REPORTED AT THE REVENUE CODE LINE LEVEL	16 – Claim/service lacks information which is needed for adjudication.	M20 - Missing/incomplete/invalid HCPCS.	Enter surgical procedure code(s) on claim line(s) and resubmit claim.
547	PRINCIPAL SURG PROC AND DTE REQUIRED	16 – Claim/service lacks information which is needed for adjudication.	MA66 - Incomplete/invalid principal procedure code and/ or date.	Enter the surgical procedure code and date in field 74 on ECF.
548	OTHER SURG PROC AND DATE MUST BE PRESENT	16 – Claim/service lacks information which is needed for adjudication.	M67 - Incomplete/invalid other procedure code(s) and/ or date(s).	Enter the surgical procedure codes and dates in fields 74 A - E.

APPENDIX 1   EDIT CODES, CARCS/RARCS, AND RESOLUTIONS

Edit Code	Description	CARC	RARC	Resolution
550	REPLACE/VOID BILL/ORIGINAL CCN MISSING	16 – Claim/service lacks information which is needed for adjudication.	M47 - Incomplete/invalid internal or document control number.	Check the remittance advice for the paid claim you are trying to replace or cancel to find the CCN. Enter the CCN in field 64.
551	TYPE ADMISSION/SOURCE CODE INCONSISTENT	16 – Claim/service lacks information which is needed for adjudication.	MA41 - Incomplete/invalid type of admission.	Check the most current edition of the NUBC manual for source of admission. Enter the valid Medicaid source of admission code in field 15.
552	MEDICARE INDICATED/NO MEDICAID LIABILITY	23 - Payment adjusted because charges have been paid by another payer.		**CMS-1500 CLAIM:** Medicare coverage was indicated on claim form. Make sure fields 24, 25, and 26 on ECF are correct and resubmit. **UB CLAIM:** Medicare coverage was indicated on claim form. Make sure fields 50, 54, and 60 on ECF are correct and resubmit.
553	ALLOW AMT=ZERO/UNABLE TO DETERMINE PYMT	16 – Claim/service lacks information which is needed for adjudication.		Information is incorrect or missing which is necessary to allow the Medicaid system to calculate the payment for the claim. If this edit code appears alone on an outpatient claim, check for valid revenue and CPT codes. If this edit code appears alone on an inpatient claim, check for valid Accommodation Revenue Codes. If this edit code appears with other edit codes, it may be resolved by correcting the other edit codes.
554	VALUE CODE/3RD PARTY PAYMENT INCONSIST	16 – Claim/service lacks information which is needed for adjudication.	MA92 - Our records indicate that there is insurance primary to ours; however, you did not complete or enter accurately the required information.	If you have entered value code 14 in fields 39 through 41 A - D, you must also enter a prior payment in field 54.
555	TPL PAYMENT > PAYMENT DUE FROM MEDICAID	23 - Payment adjusted because charges have been paid by another payer.		Verify that the payment amount you have entered in field 54 is correct. If it is not, enter the correct amount. If the amount is correct, no payment from Medicaid is due. Do not resubmit claim or ECF.
557	CARR PYMTS MUST = OTHER SOURCES PYMTS	22 – Payment adjusted because this care may be covered by another payer per coordination of benefits.	MA92 - Our records indicate that there is insurance primary to ours; however, you did not complete or enter accurately the required information.	If any amount appears in field 28, you must indicate a third party payment. If there is no third party insurance involved, delete information entered in field 26 and/or field 28 by drawing a red line through it.
558	REVENUE CHGS NOT WITHIN +- $1 OF TOTAL	16 – Claim/service lacks information which is needed for adjudication.	M54 - Did not complete or enter the correct total charges for services rendered.	Recalculate your revenue charges. Also check the resolution column on the ECF. If there is a "D" on any line, that line has been deleted by you on a previous cycle. Charges on these lines should no longer be added into the total charges.

APPENDIX 1   EDIT CODES, CARCS/RARCS, AND RESOLUTIONS

Edit Code	Description	CARC	RARC	Resolution
559	MEDICAID PRIOR PAYMENT NOT ALLOWED	B13 - Previously paid. Payment for this claim/service may have been provided in a previous payment.		Prior payment from Medicaid (field 54 A - C) should never be indicated on a claim or ECF.
560	REVENUE CODES INCONSISTENT	16 – Claim/service lacks information which is needed for adjudication.	M50 - Incomplete/invalid revenue codes.	Revenue code 100 is an all-inclusive revenue code and cannot be used with any other revenue code except 001, which is the total charges revenue code.
561	CLAIM ALREADY DEBITED (RETRO-MEDICARE), CANNOT ADJUST	23-Payment adjusted due to impact of prior payer (s) adjudication including payments and/or adjustments	N185 - Do not resubmit this claim/service.	Retroactive Medicare claim already debited or scheduled for debit. Cannot adjust this claim. Contact Medicaid Insurance Verification Services (MIVS) for further assistance.
562	CLAIM ALREADY DEBITED (HEALTH CLAIM), CANNOT ADJUST	23-Payment adjusted due to impact of prior payer (s) adjudication including payments and /or adjustments	N185 - Do not resubmit this claim/service.	Retroactive Healthcare claim already debited or scheduled for debit. Cannot adjust this claim. Contact Medicaid Insurance Verification Services (MIVS) for further assistance.
563	CLAIM ALREADY DEBITED (PAY & CHASE CLAIM), CANNOT ADJUST	23-Payment adjusted due to impact of prior payer (s) adjudication including payments and/or adjustments	N185 - Do not resubmit this claim/service.	Medicaid Pay & Chase claim already debited or scheduled for debit. Cannot adjust this claim. Contact Medicaid Insurance Verification Services (MIVS) for further assistance.
564	OP REV 450,459,510,511 COMB NOT ALLOWED	16 – Claim/service lacks information which is needed for adjudication.	N61-Re-bill services on separate claims	These revenue codes should never appear in combination on the same claim. If a recipient was seen in the emergency room, clinic, and treatment room on the same date of service for the same or related condition, charges for both visits should be combined under either revenue code 450, 510, or 761. If the recipient was seen in the ER and clinic on the same date of service for unrelated conditions, both visits should be billed on separate claims using the correct revenue code. If the recipient is a PEP member, and was triaged in the ER, the submitted claim should be filed with only revenue code 459. No other revenue codes should be filed with revenue code 459.

APPENDIX 1   EDIT CODES, CARCS/RARCS, AND RESOLUTIONS

Edit Code	Description	CARC	RARC	Resolution
565	THIRD PARTY PAYMENT/NO 3RD PARTY ID	22 – Payment adjusted because this care may be covered by another payer per coordination of benefits.	MA92 - Our records indicate that there is insurance primary to ours; however, you did not complete or enter accurately the required information.	If a prior payment is entered in field 54, information in all other TPL-related fields (50 and 60) must also be entered.
566	EMERG OP SERV/PRIN DIAG DOES NOT JUSTIFY	16 – Claim/service lacks information which is needed for adjudication.	MA63 Incomplete/invalid principal diagnosis code.	Check to make sure that the correct diagnosis code was billed. If not, enter the correct diagnosis code and resubmit the ECF.
567	NONCOV CHARGES > OR = TOTAL CHARGES	16 – Claim/service lacks information which is needed for adjudication.	M54 - Did not complete or enter the correct total charges for services rendered.	Check the total of non-covered charges in field 48 and total charges in field 47 to see if they were entered correctly. If they are correct, no payment from Medicaid is due. If incorrect, make the appropriate correction.
568	CORRESPONDING ADJUSTMENT (VOID) IS SUSPENDED OR DENIED	107 - Claim/service denied because the related or qualifying claim/service was not previously paid or identified on this claim.	N142 - The original claim was denied. Resubmit a new claim, not a replacement claim.	Review the edit code assigned to the void adjustment claim to determine if it can be corrected. If the void adjustment claim can be corrected, make the necessary changes and resubmit the adjustment claim. Resubmit the replacement claim along with the corrected void adjustment claim.
569	ORIGINAL CCN IS INVALID OR ADJUSTMENT CLAIM	125 – Payment adjusted due to a submission/billing error(s). Additional information is supplied using the remittance advice remarks codes whenever applicable.	N185 – Do not resubmit this claim/service.	Check the original CCN on the Form 130 as it is either invalid or a CCN for an adjustment claim. If the CCN is invalid, enter the correct CCN and resubmit. If the CCN is for an adjustment claim, it cannot be voided or replaced.
570	OP REV 760 762, 769 COMB NOT ALLOWED	16 – Claim/service lacks information which is needed for adjudication.	N61 - Re-bill services on separate claims.	These revenue codes cannot be used in combination for the same day; bill either revenue code 762 or 769 on an outpatient claim. Verify the correct revenue code for the claim, and make the appropriate correction.
573	PRINCIPAL PROC/ADMIT/STMT DATES INCONSIS	16 – Claim/service lacks information which is needed for adjudication.	MA66 - Incomplete/invalid principal procedure code and/ or date.	Compare the date listed with the principal surgical procedure code in field 74 with the admit date in field 12 and statement covers dates in field 6. Surgery date must fall within the admit through discharge dates. Correct dates if appropriate. If dates are correct and this is a 72-hour claim, forward to your program representative.

APPENDIX 1   EDIT CODES, CARCS/RARCS, AND RESOLUTIONS

Edit Code	Description	CARC	RARC	Resolution
574	OTHER PROC/ADMIT/STMT DATES INCONSIST	16 – Claim/service lacks information which is needed for adjudication.	M67 - Incomplete/invalid other procedure code(s) and/ or date(s).	Compare the dates listed with the other surgical procedure codes (the two-digit number before the edit code will identify which date in field 74 A - E is in question) with the admit date in field 12 and statement covers dates in field 6. All surgery dates must fall within the admit through discharge dates of service. Correct dates if appropriate. If dates are correct and this is a 72-hour claim, forward to your program representative.
575	REPLACE/VOID CLM/CCN INDICATED NOT FOUND	16 – Claim/service lacks information which is needed for adjudication.	M47 - Incomplete/invalid internal or document control number.	Review the original claim and verify the claim control number (CCN) and recipient ID number from that claim. Make sure that the correct original CCN and recipient ID number are entered on the adjustment claim and resubmit the adjustment claim. **UB CLAIM:** Check the CCN you have entered in field 64 A - C with the CCN on the remittance advice of the paid claim you want to replace or cancel. Only paid claims can be replaced or cancelled. If the CCN is incorrect, write the correct CCN on the ECF. If this edit appears with other edits, it may be corrected by correcting the other edit codes. If edit code 575 and 863 are the only edits on the replacement claim, the replacement claim criteria have not been met (see Section 3 on replacement claims).
576	TYPE OF BILL AND PROVIDE TYPE INCONSIST	16 – Claim/service lacks information which is needed for adjudication.	MA30 - Incomplete invalid type of bill.	If the bill type you have entered in field 4 is 131 or 141, you must use your outpatient number in field 51. If the bill type is 111, you must use your inpatient number.
577	FP MOD. USED – PATIENT UNDER 10 OR OVER 55	4 - The procedure code is inconsistent with the modifier used, or a required modifier is missing.	N30 - Recipient ineligible for this service.	Attach appropriate support documentation to ECF and resubmit. Contact your program representative for further assistance.
587	1ST DATE OF SERV SUBSEQUENT TO LAST DOS	16 – Claim/service lacks information which is needed for adjudication.	M59 - Incomplete/invalid "to" date(s) of service.	Check the "from" and "through" dates in field 6. "From" date must be before "through" date. Be sure you check the year closely. Enter correct dates.
588	1ST DOS SUBSEQUENT TO ENTRY DATE	16 – Claim/service lacks information which is needed for adjudication.	M52 - Incomplete/invalid "from" date(s) of service.	Check the "from" date of service in field 6. Be sure to check the year closely. Enter the correct date.
589	LAST DOS SUBSEQUENT TO DATE OF RECEIPT	16 – Claim/service lacks information which is needed for adjudication.	M59 - Incomplete/invalid "to" date(s) of service.	Check the "through" date of service in field 6. Enter correct date.

APPENDIX 1   EDIT CODES, CARCS/RARCS, AND RESOLUTIONS

Edit Code	Description	CARC	RARC	Resolution
593	ADMIT DATE NOT=TO 1ST DATE OF SERVICE	16 – Claim/service lacks information which is needed for adjudication.	MA40 - Incomplete/invalid admission date.	Check the admit date in field 12 and the "from" date in field 6. They must be the same date.
594	FINAL BILL/DISCHRG DTE BEFORE LAST DOS	16 – Claim/service lacks information which is needed for adjudication.	N50 - Discharge information missing/incomplete/incorrect/ invalid.	Check the occurrence code 42 and date in fields 31 through 34 A and B, and the "through" date in field 6. These dates must be the same.
597	ACCOMODATION UNITS/STMT PERIOD INCONSIST	16 – Claim/service lacks information which is needed for adjudication.	M52 - Incomplete/invalid "from" date(s) of service.	Check the dates entered in field 6; the covered days calculated in field 7 on the ECF; the discharge date in fields 31 through 34 A - B and the units entered for accommodation revenue codes in field 42 (the discharge date and "through" date must be the same). If the dates in field 6 are correct, the system calculated the correct number of days, so the units for accommodation revenue codes should be changed. If the dates are incorrect, correcting the dates will correct the edit.
598	QIO INDICATOR 3/APPROVAL DATES REQUIRED	16 – Claim/service lacks information which is needed for adjudication.	M52 - Incomplete/invalid "from" date(s) of service.	If condition code C3 is entered in fields 31 through 34 A - B, the approved dates must be entered in occurrence span, field 35-36 A or B.
599	QIO DATES/OCCUR SPAN DATES N/SEQUENCED	16 – Claim/service lacks information which is needed for adjudication.	M52 - Incomplete/invalid "from" date(s) of service.	The dates which have been entered in field 35 - 36 A or B (occurrence span), do not coincide with any date in the statement covers dates in field 6. There must be at least one date in common in these two fields
603	REVENUE/CONDITION/VALUE CODES INCONSIST	16 – Claim/service lacks information which is needed for adjudication.	M49 - Incomplete/invalid value code(s) and/or amount(s). M50 - Incomplete/invalid revenue codes. M44 - Incomplete/invalid condition code.	Medicaid only sponsors a semi-private room. When a private room revenue code is used, condition code 39 or value codes 01 or 02 and value amounts must be on the claim. See current NUBC manual for definition of codes.
636	COPAYMENT AMOUNT EXCEEDS ALLOWED AMOUNT	3-Co-payment amount		The Medicaid recipient is responsible for a Medicaid copayment for this service/date of service. The allowed payment amount is less than the recipient's copayment amount, therefore no payment is due from Medicaid. Please collect the copayment from the Medicaid recipient.
637	COINS AMT GREATER THAN PAY AMT			Verify that the coinsurance amount is correct. If not, correct and resubmit. If the coinsurance amount is correct, attach a copy of the Medicare remittance and return to your program representative.
642	MEDICARE COST SHARING REQ COINS/DEDUCTIB	1 - Deductible Amount 2 - Coinsurance Amount		For Medicaid to consider payment of the claim, the Medicare coinsurance and deductible must be present.

APPENDIX 1   EDIT CODES, CARCS/RARCS, AND RESOLUTIONS

Edit Code	Description	CARC	RARC	Resolution
672	NET CHRG/TOTAL DAYS X DAILY RATE UNEQUAL	16 – Claim/service lacks information which is needed for adjudication.	M54-Missing/incomplete/invalid total charges	Contact your program representative.
673	REJECT LOC 6 - EXCLUDES SWING BEDS	96 - Non-covered charge(s).		Contact your program representative.
674	NH RATE - PAT DAY INC NOT = PAT DAY RATE	16 – Claim/service lacks information which is needed for adjudication.	N153-Missing/incomplete/invalid room and board rate	Contact your program representative.
690	OTHER SOURCES AMT MORE THAN MEDICAID AMT	23 - Payment adjusted because charges have been paid by another payer.		**CMS-1500 CLAIM:** Verify the dollar amount in amount received insurance (field 28) and the amount paid (field 26). If not correct, enter correct amount. If the amounts are correct, no payment is due from Medicaid — discard the ECF.
693	MENTAL HEALTH VISIT LIMIT EXCEEDED	B5 - Coverage/program guidelines were not met or were exceeded.	M86 - Service denied because payment already made for same/similar procedure within set time frame.	Contact your program area representative.
700	PRIMARY/PRINCIPAL DIAG CODE NOT ON FILE	16 – Claim/service lacks information which is needed for adjudication.	MA63 - Incomplete/invalid principal diagnosis code.	**CMS-1500 CLAIM:** Medicaid requires the complete diagnosis code as specified in the current edition of Volume I of the ICD‑9-CM manual, (including fifth digit sub-classification when listed). Check the diagnosis code in field 8 with Volume I of the ICD-9 manual. Mark through the existing code and write in the correct code. **UB CLAIM:** Medicaid requires the complete diagnosis code as specified in the current edition of the ICD-9-CM manual, (including fifth digit sub-classification when listed). Check the diagnosis code in field 67 with the ICD-9 manual. Mark through the existing code and write in the correct code.
701	SECONDARY/ OTHER DIAG CODE NOT ON FILE	16 – Claim/service lacks information which is needed for adjudication.	M64 - Incomplete/invalid other diagnosis code.	**CMS-1500 CLAIM:** Follow the resolution for edit code 700. The secondary diagnosis code appears in field 9. **UB CLAIM:** Follow the resolution for edit code 700. The secondary diagnosis code appears in field 67 A-Q.

APPENDIX 1   EDIT CODES, CARCS/RARCS, AND RESOLUTIONS

Edit Code	Description	CARC	RARC	Resolution
703	RECIP AGE/PRIM/PRINCIPAL DIAG INCONSIST	9 - The diagnosis is inconsistent with the patient's age.	MA63 - Incomplete/invalid principal diagnosis code.	**CMS-1500 CLAIM:** Check the patient's Medicaid number in field 2. A common error is entering another family member's number. Make sure the number matches the patient served. Check the diagnosis code in field 8 to be sure it is correct. Make the appropriate correction to the patient Medicaid number in field 2 or the diagnosis code in field 8. Field 11 indicates the date of birth in our system as of the claim run date. Contact your county Medicaid office if your records indicate a different date of birth. **UB CLAIM:** Check the patient's Medicaid number in field 60. A common error is entering another family member's number. Make sure the number matches the patient served. Check the diagnosis code in field 67 to be sure it is correct. Make the appropriate correction to the patient Medicaid number in field 60 or the diagnosis code in field 67. Field 10 indicates the date of birth in our system as of the claim run date. Contact your county Medicaid office if your records indicate a different date of birth.
704	RECIP AGE/SECONDARY/OTHER DIAG INCONSIST	9 - The diagnosis is inconsistent with the patient's age.	M64 - Incomplete/invalid other diagnosis code.	**CMS-1500 CLAIM:** Check the patient's Medicaid number in field 2. A common error is entering another family member's number. Make sure the number matches the patient served. Check the secondary diagnosis code in field 9 to be sure it is correct. Make the appropriate correction to the patient Medicaid number in field 2 or the secondary diagnosis code in field 9. Field 11 indicates the date of birth in our system as of the claim run date. Contact your county Medicaid office if your records indicate a different date of birth. **UB CLAIM:** Check the patient's Medicaid number in field 60. A common error is entering another family member's number. Make sure the number matches the patient served. Check the secondary diagnosis code(s) in fields 67 A-Q to be sure it is correct. Make the appropriate correction to the patient Medicaid number in field 60 or the secondary diagnosis code(s) in fields 67 A-Q. Field 10 indicates the date of birth in our system as of the claim run date. Contact your county Medicaid office if your records indicate a different date of birth.

APPENDIX 1   EDIT CODES, CARCS/RARCS, AND RESOLUTIONS

Edit Code	Description	CARC	RARC	Resolution
705	RECIP SEX/PRIM/PRINCIPAL DIAG INCONSIST	10 - The diagnosis is inconsistent with the patient's gender.	MA63 - Incomplete/invalid principal diagnosis code.	**CMS-1500 CLAIM:** Check the patient's Medicaid number in field 2. A common error is entering another family member's number. Make sure the number matches the patient served. Check the diagnosis code in field 8 to be sure it is correct. Make the appropriate correction to the patient Medicaid number in field 2 or the diagnosis code in field 8. Contact your county Medicaid office if your records indicate a different sex. **UB CLAIM:** Check the patient's Medicaid number in field 60. A common error is entering another family member's number. Make sure the number matches the patient served. Check the diagnosis code in field 67 to be sure it is correct. Make the appropriate correction to the patient Medicaid number in field 60 or the diagnosis code in field 67. Contact your county Medicaid office if your records indicate a different sex.
706	RECIP SEX/SECONDARY/OTHER DIAG INCONSIST	10 - The diagnosis is inconsistent with the patient's gender.	M64 - Incomplete/invalid other diagnosis code.	**CMS-1500 CLAIM:** Check the patient's Medicaid number in field 2. A common error is entering another family member's number. Make sure the number matches the patient served. Check the secondary diagnosis code in field 9 to be sure it is correct. Make the appropriate correction to the patient Medicaid number in field 2 or the secondary diagnosis code in field 9. Contact your county Medicaid office if your records indicate a different sex. **UB CLAIM:** Check the patient's Medicaid number in field 60. A common error is entering another family member's number. Make sure the number matches the patient served. Check the secondary diagnosis code(s) in fields 67 A-Q to be sure it is correct. Make the appropriate correction to the patient Medicaid number in field 60 or the secondary diagnosis code(s) in fields 67 A-Q. Contact your county Medicaid office if your records indicate a different sex.
707	PRIN.DIAG. NOW REQUIRES 4TH OR 5TH DIGIT	16 – Claim/service lacks information which is needed for adjudication.	MA63 - Incomplete/invalid principal diagnosis code.	**CMS-1500 CLAIM:** Medicaid requires a complete diagnosis code as specified in the current edition of the ICD-9 manual. The diagnosis code in field 8 requires a fourth or fifth digit. Mark through the existing diagnosis code and write in the entire correct code. **UB CLAIM:** Medicaid requires a complete diagnosis code as specified in the current edition of the ICD-9 manual. The diagnosis code in field 67 requires a fourth or fifth digit. Mark through the existing diagnosis code and write in the entire correct code.

APPENDIX 1   EDIT CODES, CARCS/RARCS, AND RESOLUTIONS

Edit Code	Description	CARC	RARC	Resolution
708	SEC. DIAG. NOW REQUIRES 4TH OR 5TH DIGIT	16 – Claim/service lacks information which is needed for adjudication.	M64 - Incomplete/invalid other diagnosis code.	**CMS-1500 CLAIM:** Medicaid requires a complete diagnosis code as specified in the current edition of the ICD-9 manual. The diagnosis code in field 9 requires a fourth or fifth digit. Mark through the existing diagnosis code and write in the entire correct code **UB CLAIM:** Medicaid requires a complete diagnosis code as specified in the current edition of the ICD-9 manual. The diagnosis code(s) in fields 67 A-Q requires a fourth or fifth digit. Mark through the existing diagnosis code and write in the entire correct code.
709	SERV/PROC CODE NOT ON REFERENCE FILE	96 - Non-covered charge(s).	M51-Missing/Incomplete/invalid procedure code	Check the most current manual. If the procedure code on your ECF is incorrect, mark through the code and write in the correct code. If you are confident that the code is correct, contact your program representative for assistance.
710	SERV/PROC/DRUG REQUIRES PA-NO NUM ON CLM	15 - The authorization number is missing, invalid, or does not apply to the billed services or provider.		**CMS-1500 CLAIM:** Please enter prior authorization number in field 3. **UB CLAIM:** Please enter prior authorization number in field 63.
711	RECIP SEX - SERV/PROC/DRUG INCONSISTENT	16 – Claim/service lacks information which is needed for adjudication.	MA39 - Incomplete/invalid patient's sex.	Verify the patient's Medicaid number in field 2 and the procedure code in field 17. A common error is entering another family member's Medicaid number. Make sure the number matches the patient served. Make the appropriate correction if applicable. Field 12 shows the patient's sex indicated in our system. If there is a discrepancy, contact your county Medicaid office to correct the sex on the patient's file and resubmit the ECF with a note stating the Medicaid office is correcting the sex code on the patient file. **UB CLAIM:** Verify the recipient's Medicaid number in field 60 and the procedure code in field 44.
712	RECIP AGE-PROC INCONSIST/NOT DMR RECIP	6 - The procedure/revenue code is inconsistent with the patient's age.		**CMS-1500 CLAIM:** Follow the resolution for edit code 711. Field 11 shows the patient's date of birth indicated in our system. Notify the local Medicaid office of discrepancies. Contact your program representative with any discrepancies. **UB CLAIM:** Follow the resolution for edit code 711. The top of the ECF indicates the date of birth in our system as of the claim run date.

APPENDIX 1   EDIT CODES, CARCS/RARCS, AND RESOLUTIONS

Edit Code	Description	CARC	RARC	Resolution
713	NUM OF BILLINGS FOR SERV EXCEEDS LIMIT	151 - Payment adjusted because the payer deems the information submitted does not support this many services.		**CMS-1500 CLAIM:** Check the number of units in field 22 on the specified line to be sure the correct number of units has been entered on the ECF. If the number of units is incorrect, mark through the existing number and enter the correct number. If the number of units is correct, check the procedure code to be sure it is correct. Change the procedure code if it is incorrect. If you feel the edit is invalid, attach justification to the ECF supporting the service(s) billed and resubmit to your program representative. **UB CLAIM:** The system has already paid for the procedure entered in field 44. Verify the procedure is correct. If this is a replacement claim, send the ECF with a note to your program representative.
714	SERV/PROC/DRUG REQUIRES DOC-MAN REVIEW	16 – Claim/service lacks information which is needed for adjudication.	N102-This claim has been denied without reviewing the medical record because the requested records were not received or were not received timely.	Attach pertinent documentation to the ECF and resubmit. If you are unsure what documentation is needed, call or write to your program representative. Sterilization procedures require submission of the Sterilization Consent Form, Form 1723.
715	PLACE OF SERVICE/PROC CODE INCONSISTENT	5 - The procedure code/bill type is inconsistent with the place of service.		**CMS-1500 CLAIM:** Check the procedure code in field 17 and the place of service code in field 16 to be sure that they are correct. If incorrect, make the appropriate correction on the indicated line. If you feel they are correct and that the edit is invalid, attach documentation verifying the procedure was done in that place of service.
716	PROV TYPE INCONSISTENT WITH PROC CODE	8 - The procedure code is inconsistent with the provider type/ specialty (taxonomy).		**CMS-1500 CLAIM:** Verify that the correct code in field 17 or 19 was billed. If incorrect, make the appropriate correction. If correct, return ECF with documentation.
717	SERV/PROC/DRUG NOT COVERED ON DOS	A1 – Claim/Service denied.		**CMS-1500 CLAIM:** Check the procedure code in field 17 and the date of service in field 15 on the indicated line to be sure both are correct. The procedure code may have been deleted from the program or changed to another procedure code.
718	PROC REQUIRES TOOTH NUMBER/SURFACE INFO	16 – Claim/service lacks information which is needed for adjudication.	N37 - Tooth number/letter required. N75 - Missing or invalid tooth surface information.	The procedure requires either a tooth number and/or surface information in fields 15 and 16 on the ECF.

APPENDIX 1   EDIT CODES, CARCS/RARCS, AND RESOLUTIONS

Edit Code	Description	CARC	RARC	Resolution
719	SERV/PROC/DRUG ON PREPAYMENT REVIEW	133 - The disposition of this claim/service is pending further review.	M87-Claim/service subjected to CFO-CAP prepayment in review	Check the prior approval. If the number is not correct, mark through the incorrect number and write the correct number in red. If information on the claim does not match the information on the prior approval, strike through the incorrect information and write the correct information in red. (i.e., Procedure Code/Modifier).
720	MODIFIER 22 REQUIRES ADD'L DOCUMENT	16 – Claim/service lacks information which is needed for adjudication.	M69 - Paid at the regular rate, as you did not submit documentation to justify modifier 22.	Return ECF with documentation and statement of justification of unusual procedural services to your program representative.
721	CROSSOVER PRICING RECORD NOT FOUND	A1 – Claim/Service denied	N8-Crossover claim denied by previous payer and complete claim data not forwarded. Resubmit this claim to this payer to provide adequate data to adjudication	Pricing record not found for the specific procedure code and modifier being billed. Please verify that correct procedure code and modifier were submitted. For further assistance, please contact your program representative.
722	PROC MODIFIER and SPEC PRICING NOT ON FILE	4 - The procedure code is inconsistent with the modifier used, or a required modifier is missing.	N65 - Procedure code or procedure rate count cannot be determined, or was not on file, for the date of service/provider.	Verify that the correct procedure code and modifier were submitted. If incorrect, make the appropriate change. If correct, return ECF to your program representative with support documentation. **Note:** The Medicaid pricing system is programmed specifically for procedure codes, modifiers, and provider specialties. If these are submitted in the wrong combination, the system searches but cannot "find" a price, and the line will automatically reject with edit code 722.
724	PROCEDURE CODE REQUIRES BILLING IN WHOLE UNITS	16 – Claim/service lacks information which is needed for adjudication.	M53 –Missing/incomplete/invalid days or units of service.	Contact your program representative.
727	DELETED PROCEDURE CODE/CK CPT MANUAL	16 – Claim/service lacks information which is needed for adjudication.	M51 - Incomplete/invalid, procedure code(s) and/or rates, including "not otherwise classified" or "unlisted" procedure codes submitted without a narrative description or the description is insufficient. (Add to message by Medicare carriers only: "Refer to the HCPCS Directory. If an appropriate procedure code(s) does not exist, refer to Item 19 on the HCFA-1500 instructions.")	**CMS-1500 CLAIM:** Check the procedure code in field 17 and the date of service in field 15 to verify their accuracy. **UB CLAIM:** Check the procedure code in field 44 and the date of service in field 45 to verify their accuracy.

APPENDIX 1   EDIT CODES, CARCS/RARCS, AND RESOLUTIONS

Edit Code	Description	CARC	RARC	Resolution
732	PAYER ID NUMBER NOT ON FILE	22 – Payment adjusted because this care may be covered by another payer per coordination of benefits.	M56 - Incomplete/invalid provider payer identification.	**CMS-1500 CLAIM:** Refer to codes listed under INSURANCE POLICY INFORMATION on ECF or the carrier code list in this manual or on the SC DHHS website at **http://www.scdhhs.gov**. Enter the correct carrier code in field 24 and resubmit. **UB CLAIM:** Refer to codes listed under INSURANCE POLICY INFORMATION on ECF or the carrier code list in this manual or on the SC DHHS website at **http://www.scdhhs.gov**. Enter the correct carrier code in field 50 on the ECF and resubmit.
733	INS INFO CODED, PYMT OR DENIAL MISSING	22 – Payment adjusted because this care may be covered by another payer per coordination of benefits.	MA92 - Our records indicate that there is insurance primary to ours; however, you did not complete or enter accurately the required information.	**CMS-1500 CLAIM:** If any third-party insurer has not made a payment, there should be a TPL denial indicator in field 4. If all carriers have made payments, there should be no TPL denial indicator. If payment is denied (*i.e.,* applied to the deductible, policy lapsed, etc.) by either primary insurance carrier, put a "1" (denial indicator) in field 4 and 0.00 in field 26. If payment is made, remove the "1" from field 4 and enter the amount(s) paid in fields 26 and 28. Adjust the net charge in field 29. If no third party insurance was involved, delete information entered in fields 24 and 25 by drawing a red line through it. **UB CLAIM:** If any third-party insurer has not made a payment, there should be a TPL occurrence code and date in fields 31-34. If payment is denied show 0.00 in field 54. If payment is made enter the amount in field 54.
734	REVENUE CODE REQUIRES UNITS	16 – Claim/service lacks information which is needed for adjudication.	M53 - Did not complete or enter the appropriate number (one or more) of days or unit(s) of service.	The revenue code listed in field 42 requires units of service in field 46.
735	REVENUE CODE REQUIRES AN ICD-9 SURGICAL PROCEDURE OR DELIVERY DIAGNOSIS CODE	16 – Claim/service lacks information which is needed for adjudication..	M76 – Incomplete/invalid patient's diagnosis(es) and condition(s).	On inpatient claims w/ revenue codes 360 OR, 361 OR-Minor, or 369 OR-Other, an ICD-9 surgical code is required in fields 74 A-E. On inpatient claims w/ revenue codes 370 Anesthesia, 710 Recovery Room, 719 Other Recovery Room or 722 Delivery Room, a delivery diagnosis code is required in fields 67 A-Q or an ICD-9 surgical code is required in fields 74 A-E.
736	PRINCIPAL SURGICAL PROCEDURE NOT ON FILE	16 – Claim/service lacks information which is needed for adjudication.	MA66 - Incomplete/invalid principal procedure code and/ or date.	Verify the correct procedure code was submitted. If incorrect, make the appropriate change. If correct, contact your program representative, as this may be a non-covered service.
737	OTHER SURGICAL PROCEDURE NOT ON FILE	16 – Claim/service lacks information which is needed for adjudication.	M67 - Incomplete/invalid other procedure code(s) and/ or date(s).	Follow the resolution for edit code 736. The two digits in front of the edit code identify which surgical procedure code is not on file.

APPENDIX 1   EDIT CODES, CARCS/RARCS, AND RESOLUTIONS

Edit Code	Description	CARC	RARC	Resolution
738	PRINCIPAL SURG PROC REQUIRES PA/NO PA #	15 - Payment adjusted because the submitted authorization number is missing, invalid or does not apply to billed services or provider.		Return the ECF along with the operative note and discharge summary only if claim meets one or more of the following criteria: The patient has Medicare; the admission is coded as "Emergency" or "Urgent"; the patient received retroactive eligibility coverage.
739	OTHER SURG PROC REQUIRES PA/NO PA NUMBER	15 - Payment adjusted because the submitted authorization number is missing, invalid or does not apply to billed services or provider.		Follow the resolution for edit 738. The two digits in front of the edit identify which other surgical procedure requires the prior authorization number.
740	RECIP SEX/PRINCIPAL SURG PROC INCONSIST	7 - The procedure/revenue code is inconsistent with the patient's gender.		Verify the recipient's Medicaid number (field 60) and the procedure code in field 74. A common error is entering another family member's Medicaid number. Make sure the number matches the recipient served. Make the appropriate correction if applicable. Check the recipient's sex listed on the ECF. If there is a discrepancy, contact your county Medicaid office to correct the sex on the recipient's file. After Medicaid has made the correction, send the ECF to your program representative.
741	RECIP SEX/OTHER SURG PROC INCONSISTENT	7 - The procedure/revenue code is inconsistent with the patient's gender.		Follow resolution for edit code 740. The two digits in front of the edit code identify which other surgical procedure code in field 74 A - E is inconsistent with the recipient's sex.
742	RECIP AGE/PRINCIPAL SURG PROC INCONSIST	6 - The procedure/revenue code is inconsistent with the patient's age.		Verify the recipient's Medicaid ID number (field 60) and the procedure code in field 74. A common error is entering another family member's Medicaid number. Make sure the number matches the recipient served. Make the appropriate correction if applicable. Check the recipient's date of birth listed on the ECF. If there is a discrepancy, contact your county Medicaid office to correct the date of birth on the recipient's file. After Medicaid has made the correction, send the ECF to your program representative.
743	RECIPIENT AGE/OTHER SURG PROC INCONSIST	6 - The procedure/revenue code is inconsistent with the patient's age.		Follow the resolution for edit code 742. The two digits in front of the edit code identify which other surgical procedure code in field 74 A - E is inconsistent with the recipient's age.
746	PRINCIPAL SURG PROC EXCEEDS FREQ LIMIT	96 - Non-covered charge(s).		The system has already paid for the procedure entered in field 74. Verify the procedure code is correct. If this is a replacement claim, send the ECF with a note to your program representative.

APPENDIX 1   EDIT CODES, CARCS/RARCS, AND RESOLUTIONS

Edit Code	Description	CARC	RARC	Resolution
747	OTHER SURG PROC EXCEEDS FREQ LIMIT	96 - Non-covered charge(s).		Follow the resolution for edit code 746. The two digits in front of the edit code identify which other surgical procedure's (field 74 A - E) frequency limitation has been exceeded.
748	PRINCIPAL SURG PROC REQUIRES DOC	16 – Claim/service lacks information which is needed for adjudication.	N102-This claim has been denied without reviewing the medical record because the requested records were not received or were not received timely.	Attach documentation (discharge summary and operative note only) for the principal surgical procedure in field 74 to the ECF and return to the following address: DHHS Division of Hospitals Attention: Medical Service Review PO Box 8206 Columbia, SC 29202-8206 Documentation will not be reviewed or retained by Medicaid until the provider corrects all other edits. Always refer to Sections 2 and 3 for specific Medicaid coverage guidelines and documentation requirements.
749	OTHER SURG PROC REQUIRES DOC/MAN REVIEW	16 – Claim/service lacks information which is needed for adjudication.	N102-This claim has been denied without reviewing the medical record because the requested records were not received or were not received timely.	Follow the resolution for edit code 748 for the other surgical procedure in field 74 A-E. Two digits in front of the edit code identify which other surgical procedure requires documentation. Documentation will not be reviewed or retained by Medicaid until the provider corrects all other edits. Always refer to Sections 2 and 3 for specific Medicaid coverage guidelines and documentation requirements.
750	PRIN SURG PROC NOT COV OR NOT COV ON DOS	96 - Non-covered charge(s).		Check the procedure code in field 74 and the date of service to verify their accuracy. Check to see if the procedure code in field 74 is listed on the non-covered surgical procedures list in this manual. Check the most recent addition of the ICD to be sure the code you are using has not been deleted or changed to another code.
751	OTHER SURG PROC NOT COV/NOT COV ON DOS	96 - Non-covered charge(s).		Follow the resolution for edit code 750. The two digits in front of the edit code identify which other surgical procedure code in field 74 A - E is not covered on the date of service.
752	PRINCIPAL SURGICAL PROCEDURE ON REVIEW	133 - The disposition of this claim/service is pending further review.		Attach documentation which supports the principal surgical procedure in field 74 (discharge summary and operative notes) to the ECF and return to the address on the ECF.
753	OTHER SURGICAL PROCEDURE ON REVIEW	133 - The disposition of this claim/service is pending further review.		Follow the resolution for edit code 752. The two digits in front of the edit code identify which other surgical procedure code in field 74 A - E is not medically necessary or on review.

APPENDIX 1   EDIT CODES, CARCS/RARCS, AND RESOLUTIONS

Edit Code	Description	CARC	RARC	Resolution
754	REVENUE CODE NOT ON FILE	16 – Claim/service lacks information which is needed for adjudication.	M50 - Incomplete/invalid revenue code(s).	Revenue code is invalid. Verify revenue code.
755	REVENUE CODE REQUIRES PA/PEND FOR REVIEW	133 - The disposition of this claim/service is pending further review.		Please enter prior authorization number in field 63 on ECF and resubmit.
756	PRINCIPAL DIAG REQUIRES PA/NO PA NUMBER	15 - Payment adjusted because the submitted authorization number is missing, invalid, or does not apply to the billed services or provider.		**CMS-1500 CLAIM:** Enter prior authorization number in field 3 on ECF. **UB CLAIM:** Enter prior authorization number in field 63 on ECF.
757	OTHER DIAG REQUIRES PA/NO PA NUMBER	15 - Payment adjusted because the submitted authorization number is missing, invalid, or does not apply to the billed services or provider.		**CMS-1500 CLAIM:** Enter prior authorization number in field 3 on ECF. **UB CLAIM:** Enter prior authorization number in field 63 on ECF.
758	PRIM/PRINCIPAL DIAG REQUIRES DOC	16 – Claim/service lacks information which is needed for adjudication.	N223-Missing documentation of benefit to the patient during the initial treatment period.	If primary diagnosis is correct, attach pertinent documentation (*i.e.* operative report, chart notes, etc.) to ECF and resubmit.
759	SEC/OTHER DIAG REQUIRES DOC/MAN REVIEW	16 – Claim/service lacks information which is needed for adjudication.	N223-Missing documentation of benefit to the patient during the initial treatment period.	If primary diagnosis is correct, attach pertinent documentation (*i.e.* operative report, chart notes, etc.) to ECF and resubmit.
760	PRIMARY DIAG CODE NOT COVERED ON DOS	96 - Non-covered charge(s).		Check the current ICD-9 manual to verify that the primary diagnosis is correctly coded. If the diagnosis code is correct, then it is not covered.
761	SEC/OTHER DIAG CODE NOT COVERED ON DOS	96 - Non-covered charge(s).		Check the current ICD-9 manual to verify that the secondary or other diagnosis is correctly coded. If the diagnosis code is correct, then it is not covered.
762	PRINCIPAL DIAG ON REVIEW/MANUAL REVIEW	133 - The disposition of this claim/service is pending further review.		Return ECF with required documentation (history, physical, and discharge summary) for review to the following address: 　　　DHHS 　　　Division of Hospitals 　　　Attention: Medical Service Review 　　　PO Box 8206 　　　Columbia, SC 29202-8206

APPENDIX 1   EDIT CODES, CARCS/RARCS, AND RESOLUTIONS

Edit Code	Description	CARC	RARC	Resolution
763	OTHER DIAG ON REVIEW/MANUAL REVIEW	133 - The disposition of this claim/service is pending further review.		Follow the resolution for edit code 762. The two digits before the edit code identify which other diagnosis code in fields 67 A-Q requires manual review by DHHS.
764	REVENUE CODE REQUIRES DOC/MANUAL REVIEW	16 – Claim/service lacks information which is needed for adjudication.	N102-This claim has been denied without reviewing the medical record because the requested records were not received or were received timely.	Please attach pertinent documentation to ECF and resubmit.
765	RECIPIENT AGE/REVENUE CODE INCONSIST	6 - The procedure/revenue code is inconsistent with the patient's age.		Check the recipient's Medicaid ID number. A common error is entering another family member's number. Make sure the number matches the recipient served. Check the revenue code in field 42 to be sure it is correct. Make the appropriate correction to the recipient number or to the revenue code in field 42. The date of birth on the ECF indicates the date of birth in our system as of the claim run date. Call your county Medicaid Eligibility office if your records indicate a different date of birth. After the county Medicaid Eligibility office has made the correction, send the ECF to your program representative.
766	NEED TO PRICE OP SURG			Verify that the correct procedure code was entered in field 44. If the procedure code on the ECF is incorrect, mark through the code with red ink and write in the correct code. If the code is correct, resubmit the ECF with documentation (operative notes, discharge summary) to your program representative.
768	ADMIT DIAGNOSIS CODE NOT ON FILE	16 – Claim/service lacks information which is needed for adjudication.	MA65 - Incomplete/invalid admitting diagnosis.	Follow the resolution for edit code 700.
769	ASST. SURGEON NOT ALLOWED FOR PROC CODE	B7 - This provider was not certified/eligible to be paid for this procedure/service on this date of service.		Procedure does not allow reimbursement for assistant surgeon. If the edit appears unjustified or an assistant surgeon was medically necessary, attach documentation to the ECF to justify the assistant surgeon and resubmit for review.
771	PROV NOT CERTIFIED TO PERFORM THIS SERV	B7 - This provider was not certified/eligible to be paid for this procedure/service on this date of service.		**CMS-1500 CLAIM:** Verify the procedure code in field 17. If correct, attach FDA certificate to the ECF and resubmit. If you are not a certified mammography provider, or a lab provider, this edit code is not correctable.
772	ANESTHESIA UNITS NOT IN MIN/MAX RANGE	16 – Claim/service lacks information which is needed for adjudication.	M53 - Did not complete or enter the appropriate number (one or more) day(s) or unit(s) of service.	Verify the number of units in field 22 is correct. If not, make the appropriate correction. If correct, attach anesthesia records to the ECF and resubmit.

APPENDIX 1   EDIT CODES, CARCS/RARCS, AND RESOLUTIONS

Edit Code	Description	CARC	RARC	Resolution
773	INAPPROPRIATE PROCEDURE CODE USED	16 – Claim/service lacks information which is needed for adjudication.	M51 - Incomplete/invalid, procedure code(s) and/or rates, including "not otherwise classified" or "unlisted" procedure codes submitted without a narrative description or the description is insufficient. (Add to message by Medicare carriers only: "Refer to the HCPCS Directory. If an appropriate procedure code(s) does not exist, refer to Item 19 on the HCFA-1500 instructions.") N56 – Procedure code billed is not correct for the service billed.	Verify the procedure code in field 17. If incorrect, enter the correct code in field 17 on the ECF and resubmit.
774	LINE ITEM SERV CROSSES STATE FISCAL YEAR	16 – Claim/service lacks information which is needed for adjudication.	N63-Rebill services on separate claim lines.	Change the units in field 22 to reflect days billed on or before 6/30. Add a line to the ECF to reflect days billed on or after 07/01.
778	SEC CARRIER PRIOR PAYMENT NOT ALLOWED	16 – Claim/service lacks information which is needed for adjudication.	MA04 - Secondary payment cannot be considered without the identity of or payment information from the primary payer. The information was either not reported or was illegible.	Prior payment (field 54) for a carrier secondary to Medicaid should not appear on claim.
779	PA REQUIRED ON INP UB WITH DAODAS DRG	15 - The authorization number is missing, invalid, or does not apply to the billed services or provider.		A prior authorization must be obtained. Refer to the Alcohol and Drug Services section in the provider manual for instructions or call toll free at (800) 374-1390 or in the Columbia area at (803) 896-5988.

APPENDIX 1   EDIT CODES, CARCS/RARCS, AND RESOLUTIONS

Edit Code	Description	CARC	RARC	Resolution
780	REVENUE CODE REQUIRES PROCEDURE CODE	16 – Claim/service lacks information which is needed for adjudication.	M51 - Incomplete/invalid, procedure code(s) and/or rates, including "not otherwise classified" or "unlisted" procedure codes submitted without a narrative description or the description is insufficient. (Add to message by Medicare carriers only: "Refer to the HCPCS Directory. If an appropriate procedure code(s) does not exist, refer to Item 19 on the HCFA-1500 instructions.")	Some revenue codes (field 42) require a CPT/HCPCS code in field 44. Enter the appropriate CPT/HCPCS code in field 44. A list of revenue codes that require a CPT/HCPCS code is located under the outpatient hospital section in the provider manual.
786	ELECTIVE ADMIT,PROC REQ PRE-SURG JUSTIFY	197 - Precertification / authorization/notification absent.		When type of admission (field 14) is elective, and the procedure requires prior authorization, a prior authorization number from QIO must be entered in field 63.
791	PRIN SURG PROC NOT CLASSED-MANUAL REVIEW	16 – Claim/service lacks information which is needed for adjudication.	M85 - Subjected to review of physician evaluation and management services.	Verify that the correct procedure code was entered in field 74. If the procedure code on the ECF is incorrect, mark through the code and write in the correct code. If you are confident that the code is correct, resubmit the ECF with documentation (operative note and discharge summary) to your program representative.
792	OTHER SURG PROC NOT CLASSED - MANUAL REV	16 – Claim/service lacks information which is needed for adjudication.	M85 - Subjected to review of physician evaluation and management services.	Follow the resolution for edit code 791. The two digits in front of the edit identify which other procedure code has not been classed.
795	SURG RATE CLASS/NOT ON FILE-NOT COV DOS	16 – Claim/service lacks information which is needed for adjudication.	N65-Procedure code or procedure rate count cannot be determined, or was not on file, for the date of service/provider.	Verify that the correct procedure code and date of service was entered. If the procedure code on the ECF is incorrect, mark through the code and write in the correct code. If you are confident that the code is correct, resubmit the ECF with documentation (operative note and discharge summary) to your program representative.
796	PRINC DIAG NOT ASSIGNED LEVEL-MAN REVIEW	133 - The disposition of this claim/service is pending further review.		Verify that the correct diagnosis code (field 67) was submitted. If incorrect, make the appropriate change. If correct, return the ECF to your program representative with support documentation.
797	OTHER DIAG NOT ASSIGNED LEVEL-MAN REVIEW	133 - The disposition of this claim/service is pending further review.		Follow the resolution for edit code 796. The two digits in front of the edit code identify which other diagnosis code has not been assigned a level.

APPENDIX 1   EDIT CODES, CARCS/RARCS, AND RESOLUTIONS

Edit Code	Description	CARC	RARC	Resolution
798	SURGERY PROCEDURE REQUIRES PA# FROM CMR	197 - Precertification / authorization/notification absent.	N241 - Incomplete/invalid review organization approval.	**CMS-1500 CLAIM:** Contact CMR for authorization number. Enter authorization number in field 3 on the ECF. **UB CLAIM:** Contact CMR for authorization number. Enter authorization number in field 63 on the ECF.
799	OP PRIN/OTHER PROC REQ QIO APPROVAL	197 - Precertification / authorization/notification absent.	N241 - Incomplete/invalid review organization approval.	Prior authorization is required from QIO. Enter PA number in field 63.
808	HEALTH OPPORTUNITY ACCOUNT (HOA) IN DEDUCTIBLE PERIOD	A1 – Claim/Service denied.	MA07 – The claim information has also been forwarded to Medicaid for review.	Contact your program area representative.
843	RTF SERVICES REQUIRE PA	15 - The authorization number is missing, invalid, or does not apply to the billed services or provider.		Enter the prior authorization number from Form 254 in field 63 on the claim form and resubmit.
844	IMD SERVICES REQUIRE PA	15 - The authorization number is missing, invalid, or does not apply to the billed services or provider.		Enter the prior authorization number from Form 254 in field 63 on the claim form and resubmit.
845	BH SERVICES REQUIRE PA	15 - The authorization number is missing, invalid, or does not apply to the billed services or provider.		Examine field 3 on the ECF. If there is no PA number on the ECF, enter the PA number, in red, in field 3 on the ECF. The PA number may be found on the DHHS Form 252/254. If a PA number is on the ECF, check to be sure the PA number matches the number on the form 252/254. If the prefix is incorrect, cross through the incorrect number and enter the correct PA number in red. If any other problems occur, contact your program representative.
850	HOME HEALTH VISITS FREQUENCY EXCEEDED	B1 - NON-Covered visits.		Discard the ECF.
851	DUP SERVICE, PROVIDER SPEC and DIAGNOSIS	18 - Duplicate Claim/service.		Verify that the procedure code and the diagnosis code were billed correctly. If incorrect, make the appropriate corrections. If correct, the first provider will be paid. The second provider of the same practice specialty will not be reimbursed for services rendered for the same diagnosis.

APPENDIX 1   EDIT CODES, CARCS/RARCS, AND RESOLUTIONS

Edit Code	Description	CARC	RARC	Resolution
852	DUPLICATE PROV/ SERV FOR DATE OF SERVICE	B13 - Previously paid. Payment for this claim/service may have been provided in a previous payment.		1. Review the ECF for payment date, which appears within a block named Claims/Line Payment Information, on the right side under other edit information. 2. Check the patient's financial record to see whether payment was received. If so, discard the ECF. 3. If two or more of the same procedures for the same date of service should have been paid and you only received payment for the first, attach supporting documentation and resubmit. **FOR PHYSICIANS:** 1. Review the ECF for payment date, which appears within a block named Claims/Line Payment Information, on the right side under other edit information. 2. Check the patient's financial record to see if payment was received. If so, discard the ECF. 3. If two or more of the same procedures were performed on the same date of service and only one procedure was paid, make the appropriate change to the modifier (field 18) to indicate a repeat procedure (i.e. 76, WJ or 51). **All other provider/claim types:** Contact your program representative.
853	DUPLICATE SERV/DOS FROM MULTIPLE PROV	B20 - Payment adjusted because procedure/service was partially or fully furnished by another provider.		Medicaid will not reimburse a physician if the procedure was also performed by a laboratory, radiologist, or a cardiologist. If none of the above circumstances apply, attach documentation and resubmit.
854	VISIT WITHIN SURG PKG TIME LIMITATION	16 – Claim/service lacks information which is needed for adjudication.	M144 - Pre-/post-operative care payment is included in the allowance for the surgery/procedure.	If the visit is related to the surgery and is the only line on the ECF, disregard the ECF. The visit will not be paid. If the visit is related to the surgery and is on the ECF with other payable lines, draw a red line through the line with the 854 edit and resubmit. This indicates you do not expect payment for this line. If the visit is unrelated to the surgical package, enter the appropriate modifier, 24 or 25, in field 18 on the ECF and resubmit.
855	SURG PROC/PAID VISIT/TIME LIMIT CONFLICT	151 - Payment adjusted because the payer deems the information submitted does not support this many services.		Either request recoupment of the visit to pay the surgery, or, if the visit and surgery are non-related, send documentation with ECF to justify the circumstances.

APPENDIX 1   EDIT CODES, CARCS/RARCS, AND RESOLUTIONS

Edit Code	Description	CARC	RARC	Resolution
856	2 PRIM SURGEON BILLING FOR SAME PROC/DOS	B20 - Payment adjusted because procedure/service was partially or fully furnished by another provider.		Check to see if individual provider number (in field 19 on the ECF) is correct, and the appropriate modifier is used to indicate different operative session, assistant surgeon, surgical team, etc. Make appropriate changes to ECF and resubmit. If no modifier is applicable, and field is correct, resubmit ECF with documentation to your program manager.
857	DUP LINE – REV CODE, DOS, PROC CODE, MODIFIER	18 - Duplicate claim/service.		The two-digit number in front of the edit code identifies which line of field 42 or 44 contains the duplicate code. Duplicate revenue or CPT/HCPCS codes should be combined into one line by deleting the whole duplicate line and adding the units and charges to the other line.
858	TRANSFER TO ANOTHER INSTITUTION DETECTED	B20 - Payment adjusted because procedure/service was partially or fully furnished by another provider.		Contact your program representative.
859	DUPLICATE PROVIDER FOR DATES OF SERVICE	18 - Duplicate Claim/service.		Check the claims/line payment info box on the right of your ECF for the dates of previous payments that conflict with this claim. If this is a duplicate claim or if the additional charges do not change the payment amount disregard the ECF. If additional services were performed on the same day and will result in a different payment amount, complete a replacement claim. If services were not done on the same date of service, a new claim should be filed with the correct date of service. Itemized statements for both the paid claim and new claim(s) with an inquiry form explaining the situation should be attached and sent to your program representative.
860	RECIP SERV FROM MULTI PROV FOR SAME DOS	B20 - Payment adjusted because procedure/service was partially or fully furnished by another provider.		This edit most frequently occurs with a transfer from one hospital to another. One or both of the hospitals entered the wrong "from" or "through" dates. Verify the date(s) of service. If incorrect, enter the correct dates of service and return the ECF. If dates are correct, forward the ECF with documentation (discharge summary, transfer document, or ambulance document) to your program representative. If the claim has a 618 carrier code in field 50, the claim may be duplicating against another provider's Medicare primary inpatient or outpatient claim, or against the provider's own Medicare primary inpatient or outpatient claim. The provider must send in the ECF with the Medicare EMB to the program representative.

APPENDIX 1   EDIT CODES, CARCS/RARCS, AND RESOLUTIONS

Edit Code	Description	CARC	RARC	Resolution
863	DUPLICATE PROV/SERV FOR DATES OF SERVICE	B13 - Previously paid. Payment for this claim/service may have been provided in a previous payment.		Check the claims/line payment information box on the right of the ECF for the dates of paid claims that conflict with this claim. If all charges are paid for the date(s) of service disregard ECF. Send a replacement claim if it will result in a different payment amount. Payment changes usually occur when there is a change in the inpatient DRG or reimbursement type, or a change in the outpatient reimbursement type.
865	DUP PROC/SAME DOS/DIFF ANES MOD	B13 - Previously paid. Payment for this claim/service may have been provided in a previous payment.		You have been paid for this procedure with a different modifier. Verify by the anesthesia record the correct modifier. If the paid claim is correct, discard the ECF. If the paid claim is incorrect, contact your program representative.
866	NURS HOME CLAIM DATES OF SERVICE OVERLAP	B13 - Previously paid. Payment for this claim/service may have been provided in a previous payment.	M80 - Not covered when performed during the same session/date as a previously processed service for patient.	Contact your program representative.
867	DUPLICATE ADJ< ORIGINAL CLM ALRDY VOIDED			Provider has submitted an adjustment claim for an original claim that has already been voided. An adjustment cannot be made on a previously voided claim.
868	RECIP RECEIVING SAME SVC FROM DIFFERENT PROV FOR DOS	B13 - Previously paid. Payment for this claim/service may have been provided in a previous payment.	M80 - Not covered when performed during the same session/date as a previously processed service for patient.	Contact your program representative.
877	SURGICAL PROCS ON SEPERATE CLMS/SAME DOS	B13 - Previously paid. Payment for this claim/service may have been provided in a previous payment.		This edit indicates payment has been made for a primary surgical procedure at 100%. The system has identified that another surgical procedure for the same date of service was paid after manual pricing and approval. This indicates a review is necessary to ensure correct payment of the submitted claim. Enter appropriate modifiers to indicate different operative sessions, assistant surgeon, surgical team, etc. Submit ECF with documentation to your program representative.
883	CARE CALL SERVICE BILLED OUTSIDE THE CARE CALL SYSTEM	B7 – This provider was not certified/eligible to be paid for this procedure/service on this date of service.	N30 - Recipient ineligible for this service.	Contact your program representative for further assistance.

APPENDIX 1   EDIT CODES, CARCS/RARCS, AND RESOLUTIONS

Edit Code	Description	CARC	RARC	Resolution
884	OVERLAPPING PROCEDURES (SERVICES) SAME DOS/SAME PROVIDER	B13 – Previously paid. Payment for this claim/service may have been provided in a previous payment.	M80 – Not covered when performed during the same session/date as a previously processes service for patient.	Contact your program representative for further assistance.
885	PROVIDER BILLED AS ASST and PRIMARY SURGEO	B13 - Previously paid. Payment for this claim/service may have been provided in a previous payment.		Verify which surgeon was primary and which was the assistant. Check the individual provider number in field 19. The modifier may need correcting to indicate different operative sessions, surgical team, etc. If you have been paid as primary surgeon and should be paid as the assistant, submit a refund with a refund form (DHHS Form 205) found in Section 5. Resubmit the ECF with documentation. Call your program representative if you have questions.
887	PROV SUBMITTING MULT CLAIMS FOR SURGERY	B13 - Previously paid. Payment for this claim/service may have been provided in a previous payment		First check your records to see if this claim has been paid. If it has, discard the ECF. If multiple procedures were performed and some have been paid, attach op note and remittance advice from original claim to ECF and send to your program representative. If two surgical procedures were performed at different times on this DOS (two different operative sessions), correct the ECF (in red) by entering the modifier 78 or 79 and resubmit.
888	DUP DATES OF SERVICE FOR EXTENDED NH CLM	B13 - Previously Paid. Payment for this claim/service may have been provided in a previous payment.	M80 - Not covered when performed during the same session/date as a previously processed service for patient.	Contact your program representative.
889	PROVIDER PREVIOUSLY PD AS AN ASST SURGEON	B13 - Previously paid. Payment for this claim/service may have been provided in a previous payment. B20 - Payment adjusted because procedure/service was partially or fully furnished by another provider.		Verify which surgeon was primary and which was the assistant. If the surgeon has been paid as the assistant, and was the primary surgeon, submit a refund with a refund form (DHHS Form 205) found in Section 5. Resubmit the ECF with documentation. Call your program representative if you have questions.

APPENDIX 1   EDIT CODES, CARCS/RARCS, AND RESOLUTIONS

Edit Code	Description	CARC	RARC	Resolution
892	DUP DATE OF SERVICE,PROC/MOD ON SAME CLM	18 - Duplicate claim/service.		**CMS-1500 CLAIM:** If duplicate services were not provided, mark through the duplicate line on the ECF. If duplicate services were provided, verify whether the correct modifier was billed. If not, make the correction in field 18 on the ECF. If duplicate services were provided and the correct duplicate modifier was billed, attach support documentation and resubmit the ECF.
893	CONFLICTING AA/QK MOD SUBMITTED SAME DOS	B20 - Payment adjusted because procedure/service was partially or fully furnished by another provider.		Claims are conflicting for the same date of service regardless of the procedure code, one with AA modifier and one with QK/QY modifier. Verify the correct modifier and/or procedure code for the date of service by the anesthesia record.
894	CONFLICTING QX/QZ MOD SUBMITTED SAME DOS	B20 - Payment adjusted because procedure/service was partially or fully furnished by another provider.		Claims are conflicting for the same date of service regardless of the procedure code, one with QX modifier and one with QZ modifier. Verify by the anesthesia record if the procedure was rendered by a supervised or independent CRNA.
895	CONFL AA and QX/QZ MOD SAME PROC/DOS	B20 - Payment adjusted because procedure/service was partially or fully furnished by another provider.		Claims have been submitted by an anesthesiologist as personally performed anesthesia services and a CRNA has also submitted a claim. Verify by the anesthesia record the correct modifier for the procedure code on the date of service.
897	MULT. SURGERIES ON CONFLICTING CLM/DOS	59 - Charges are adjusted based on multiple surgery rules or concurrent anesthesia rules.		First check your records to see if this claim has been paid. If it has, discard the ECF. If multiple procedures were performed and some have been paid, attach op note and remittance from original claim to ECF and send to your program representative. If two surgical procedures were performed at different times on this DOS (two different operative sessions), correct the ECF (in red) by entering the modifier 78 or 79 and resubmit.
899	CONFLICTING QK/QZ MOD FOR SAME DOS	B20 - Payment adjusted because procedure/service was partially or fully furnished by another provider.		Verify by the anesthesia record the correct modifier and procedure code for the date of service. If this procedure was rendered by an anesthesia team, the supervising physician should bill with QK modifier and the supervised CRNA should bill with the QX modifier. The QY modifier indicates the physician was supervising a single procedure.
900	PROVIDER ID IS NOT ON FILE	16 – Claim/service lacks information which is needed for adjudication.	N77-Missing/incomplete/invalid designated provider number	Check your records to make sure that the individual provider number in field 19 of the ECF is correct. Enter correct individual ID# in appropriate field.

APPENDIX 1   EDIT CODES, CARCS/RARCS, AND RESOLUTIONS

Edit Code	Description	CARC	RARC	Resolution
901	INDIVIDUAL PROVIDER ID NUM NOT ON FILE	16 – Claim/service lacks information which is needed for adjudication.	N77-Missing/incomplete/invalid designated provider number	**CMS-1500 CLAIM:** Check your records to make sure that the individual provider number in field 19 of the ECF is correct. Enter correct individual ID# in field 19.
902	PROVIDER NOT ELIGIBLE ON DATE OF SERVICE	B7 - This provider was not certified/eligible to be paid for this procedure/service on this date of service.		Pay-to provider not eligible on date of service. Provider was not enrolled when service was rendered. Contact your program representative for assistance.
903	INDIV PROVIDER INELIGIBLE ON DTE OF SERV	B7 - This provider was not certified/eligible to be paid for this procedure/service on this date of service.		Verify that date of service is correct. If not, correct and resubmit the ECF. If the date of service is correct, contact Medicaid Provider Enrollment at (803)788-7622 ext. 41650 regarding provider eligibility dates.
904	PROVIDER SUSPENDED ON DATE OF SERVICE	B7 - This provider was not certified/eligible to be paid for this procedure/service on this date of service.		Verify whether the date of service on ECF is correct. If not, correct and resubmit the ECF. If correct, attach a note to the ECF requesting to have the provider file updated provided the suspension has been lifted.
905	INDIVIDUAL PROVIDER SUSPENDED ON DOS	B7 - This provider was not certified/eligible to be paid for this procedure/service on this date of service.		Verify whether the date of service on ECF is correct. If not, correct and resubmit the ECF. If correct, attach a note to the ECF requesting to have the provider file updated provided the suspension has been lifted.
906	PROVIDER ON PREPAYMENT REVIEW	16 – Claim/service lacks information which is needed for adjudication.	N35 - Program Integrity/ utilization review decision.	Contact your program representative.
907	INDIVIDUAL PROVIDER ON PREPAYMENT REVIEW	16 – Claim/service lacks information which is needed for adjudication.	N35 - Program Integrity/ utilization review decision.	Contact your program representative.
908	PROVIDER TERMINATED ON DATE OF SERVICE	B7 - This provider was not certified/eligible to be paid for this procedure/service on this date of service.		Verify whether the date of service on the ECF is correct. If not, correct and resubmit the ECF. If correct, attach a note to the ECF requesting to have the provider file updated.
909	INDIVIDUAL PROVIDER TERMINATED ON DOS	B7 - This provider was not certified/eligible to be paid for this procedure/service on this date of service.		Verify whether the date of service on the ECF is correct. If not, correct and resubmit the ECF. If correct, attach a note to the ECF requesting to have the provider file updated.

APPENDIX 1   EDIT CODES, CARCS/RARCS, AND RESOLUTIONS

Edit Code	Description	CARC	RARC	Resolution
911	INDIV PROV NOT MEMBER OF BILLING GROUP	B7 - This provider was not certified/eligible to be paid for this procedure/service on this date of service.		Resubmit the ECF along with a written request to have the individual provider added to the group provider ID number.
912	PROV REQUIRES PA/NO PA NUMBER ON CLAIM	15 - The authorization number is missing, invalid, or does not apply to the billed services or provider.		Contact your program representative.
914	INDIV PROV REQUIRES PA/NO PA NUM ON CLM	15 - The authorization number is missing, invalid, or does not apply to the billed services or provider.		Contact your program representative.
915	GROUP PROV ID/NO INDIV ID ON CLAIM/LINE	16 – Claim/service lacks information which is needed for adjudication.	N77 - Missing/incomplete/invalid designated provider number	**CMS-1500 CLAIM:** Verify the rendering individual physician and enter his or her provider ID number in field 19 on ECF.
916	CRD PRIM DIAG CODE/PROV NOT CERTIFIED	B7 - This provider was not certified/eligible to be paid for this procedure/service on this date of service.		Attach appropriate support documentation to ECF and resubmit. Contact your program representative for further assistance.
917	CRD SEC DIAG CODE/PROV NOT CERTIFIED	B7 - This provider was not certified/eligible to be paid for this procedure/service on this date of service.		Attach appropriate support documentation to ECF and resubmit. Contact your program representative for further assistance.
918	CRD PROCEDURE CODE/PROV NOT CERTIFIED	B7 - This provider was not certified/eligible to be paid for this procedure/service on this date of service.		Attach appropriate support documentation to ECF and resubmit. Contact your program representative for further assistance.
919	NO PA# ON CLM/PROV OUT OF 25 MILE RADIUS	40 - Charges do not meet qualifications for emergent/urgent care.		Contact your program representative.
920	Transportation Service is covered by Contractual Transportation Broker / not covered fee-for-service	109 - Claim not covered by this payer/contractor. You must send the claim to the correct payer/contractor.	N157 - Transportation to/from this destination is not covered.	Contact your program representative.

APPENDIX 1   EDIT CODES, CARCS/RARCS, AND RESOLUTIONS

Edit Code	Description	CARC	RARC	Resolution
921	Ambulance service is payable by Contractual Transportation Broker / not covered fee-for-service	109 - Claim not covered by this payer/contractor. You must send the claim to the correct payer/contractor.	N157 - Transportation to/from this destination is not covered.	Contact your program representative.
922	URGENT SERVICE/OOS PROVIDER	16 – Claim/service lacks information which is needed for adjudication.		Contact your program representative.
923	PROVIDER TYPE / CAT. INCONSIST W/ LEVEL OF CARE	150 – Payment adjusted because the payer deems the information submitted does not support this level of service.		Contact your program representative.
924	RCF PROV/RECIP PAY CAT NOT 85 OR 86	141 - Claim adjustment because the claim spans eligible and ineligible periods of coverage.	N30 - Recipient ineligible for this service.	Contact your program representative.
925	AGES > 21 & < 65 / IMD HOSPITAL NON-COVERED	141 - Claim adjustment because the claim spans eligible and ineligible periods of coverage.	N30 - Recipient ineligible for this service.	Contact your program representative.
926	AGE 21-22/MENTAL INST SERV N/C - MAN REV	141 - Claim adjustment because the claim spans eligible and ineligible periods of coverage.	N30 - Recipient ineligible for this service.	Contact your program representative.
927	PROVIDER NOT AUTHORIZED AS HOSPICE PROV	B7 - This provider was not certified/eligible to be paid for this procedure/service on this date of service.		Contact your program representative.
928	RECIP UNDER 21/HOSP SERVICE REQUIRES PA	15 - The authorization number is missing, invalid, or does not apply to the billed services or provider.		Attach medical records to the ECF and forward to the Medical Service Reviewer.
929	NON QMB RECIPIENT	141 - Claim adjustment because the claim spans eligible and ineligible periods of coverage.	N30 - Recipient ineligible for this service.	Provider is Medicare only provider attempting to bill for a non-QMB (Medicaid only) recipient. Medicaid does provide reimbursement to QMB providers for non-QMB recipients.

APPENDIX 1   EDIT CODES, CARCS/RARCS, AND RESOLUTIONS

Edit Code	Description	CARC	RARC	Resolution
932	PAY TO PROV NOT GROUP/LINE PROV NOT SAME	16 – Claim/service lacks information which is needed for adjudication.	N77-Missing/incomplete/invalid designated provider number	Verify provider ID and/or NPI in field 1 is the same as the Provider ID and/or NPI on the line(s). If not strike through the incorrect provider ID and/or NPI and enter the correct information in the appropriate fields.
933	REV CODE 172 OR 175/NO NICU RATE ON FILE	147 - Provider contracted/ negotiated rate expired or not on file.		Contact your program representative.
934	PRIOR AUTHORIZATION NH PROV ID NOT AUTHORIZED	15 – Payment adjusted because the submitted authorization number is missing, invalid, or does not apply to the billed services or provider.		Enter the correct Nursing Facility Provider number in field #3 on the ECF (Prior Authorization) and resubmit.
935	PROVIDER WILL NOT ACCEPT TITLE 18 ASSIGNMENT	B7 - This provider was not certified/eligible to be paid for this procedure/service on this date of service.		Contact your program representative.
936	NON EMERGENCY SERVICE/OOS PROVIDER	40 - Charges do not meet qualifications for emergent/ urgent care.		If diagnosis and surgical procedure codes have been coded correctly, this outpatient service is not covered for out-of-state providers. No payment is due from South Carolina Healthy Connections (Medicaid).
938	PROV WILL NOT ACCEPT TITLE 19 ASSIGNMENT	B7 - This provider was not certified/eligible to be paid for this procedure/service on this date of service.		If provider is accepting Medicaid assignment, attach a note to the ECF to request to have the provider's file updated. If not, discard the ECF.
939	IND PROV WILL NOT ACCEPT T-19 ASSIGNMENT	B7 - This provider was not certified/eligible to be paid for this procedure/service on this date of service.		If provider is accepting Medicaid assignment, attach a note to the ECF to request to have the provider's file updated. If not, discard the ECF.
940	BILLING PROV NOT RECIP IPC PHYSICIAN	38 – Services not provided or authorized by designated (network/primary care) providers.		Contact your program representative.

APPENDIX 1   EDIT CODES, CARCS/RARCS, AND RESOLUTIONS

Edit Code	Description	CARC	RARC	Resolution
941	NPI ON CLAIM NOT FOUND ON PROVIDER FILE	208 - National Provider Identifier - Not matched.	N77 – Missing/incomplete/invalid designated provider number.	Check the NPI on the ECF to ensure it is correct. If so, register the NPI with provider enrollment. Medicaid Provider Enrollment Mailing address: PO Box 8809, Columbia, SC 29202-8809 Phone: (803) 264-1650 Fax: (803) 699-8637
942	INVALID NPI	207 - National Provider Identifier - invalid format.	N77 – Missing/incomplete/invalid designated provider number.	The NPI used on the claim is inconsistent with numbering scheme utilized by NPPES. Update the ECF with the correct NPI. Contact your program representative if you have additional questions.
943	TYPICAL PROVIDER, NO NPI ON CLAIM	206 - National Provider Identifier - missing.	N77 – Missing/incomplete/invalid designated provider number.	Typical providers must use the NPI and six-character Medicaid Legacy Provider Number or NPI only for each rendering and billing/pay-to provider. When billing with NPI only, the taxonomy code for each rendering and billing/pay-to provider must also be included. Make corrections to the ECF or resubmit a new claim.
944	TAXONOMY ON CLAIM HAS NOT BEEN REGISTERED WITH PROVIDER ENROLLMENT FOR THE NPI USED ON THE CLAIM	16 - Claim/service lacks information which is needed for adjudication.	N94 - Claim/Service denied because a more specific taxonomy code is required for adjudication.	Either update the taxonomy on the ECF so that it is one that the provider registered with SCDHHS or contact Provider Enrollment to add the taxonomy that is being used on the claim. Medicaid Provider Enrollment Mailing address: PO Box 8809, Columbia, SC 29202-8809 Phone: (803) 264-1650 Fax: (803) 699-8637
945	PROFESSIONAL COMPONENT REQUIRED FOR PROV	16 – Claim/service lacks information which is needed for adjudication.	N13 - Payment based on professional/technical component modifier(s).	The services were rendered on an inpatient or outpatient basis. Enter a "26" modifier in field 18. Services described in this manual do not require a modifier.
946	UNABLE TO CROSSWALK TO LEGACY PROVIDER NUMBER	16 - Claim/service lacks information which is needed for adjudication.	N77 – Missing/incomplete/invalid designated provider number.	Add the legacy number to the ECF and contact your program representative to clarify why the NPI could not be cross-walked.
947	ATYPICAL PROVIDER AND NPI UTILIZED ON THE CLAIM	16 - Claim/service lacks information which is needed for adjudication.	N77 – Missing/incomplete/invalid designated provider number.	Atypical providers must continue to use their legacy number on the claim. Do not include an NPI if you are an atypical provider. If you are not sure, contact your program representative.
948	CONTRACT RATE NOT ON FILE/SERV NC ON DOS	147 - Provider contracted/ negotiated rate expired or not on file.		Review your contract to verify if the correct procedure code was billed. If the contract allows billing of this procedure code, contact your program representative.

APPENDIX 1   EDIT CODES, CARCS/RARCS, AND RESOLUTIONS

Edit Code	Description	CARC	RARC	Resolution
949	CONTRACT NOT ON FILE FOR ELECTRONIC CLAIMS	16 – Claim/service lacks information which is needed for adjudication.	N51-Electronic interchange agreement not on file for provider/submitter	Contact the EDI Support Center at 1-888-289-0709 for further assistance.
950	RECIPIENT ID NUMBER NOT ON FILE	31 - Claim denied, as patient cannot be identified as our insured.		**CMS-1500 CLAIM:** Check the patient's Medicaid number in field 2 of the ECF to make sure it was entered correctly. Remember, all patient's Medicaid numbers are 10 digits (no alpha characters). If the number on the ECF is different than the number in the patient's file, mark through the incorrect number and enter the correct number above field 2. If the number you have on file is correct, call the Medicaid office in the patient's county of residence for the correct number or call the patient. **UB CLAIM:** Check the patient's Medicaid number in field 60 of the ECF to make sure it was entered correctly. Remember, all patient's Medicaid numbers are 10 digits (no alpha characters). If the number on the ECF is different than the number in the patient's file, mark through the incorrect number and enter the correct number above field 60. If the number you have on file is correct, call the Medicaid office in the patient's county of residence for the correct number or call the patient. **All other provider/claim types**: Contact your program representative.
951	RECIPIENT INELIGIBLE ON DATES OF SERVICE	26 - Expenses incurred prior to coverage. 27 - Expenses incurred after coverage terminated.		Always check the patient's Medicaid eligibility on each date of service. Medicaid eligibility may change. If the patient was eligible, contact your county Medicaid Eligibility office and have them update the patient's Medicaid eligibility on the system and send you a statement to that effect. Attach the statement to the ECF and resubmit. If the patient was not eligible for Medicaid on the date of service, the patient is responsible for your charges. If the patient was eligible for some but not all of your charges, mark through the lines when the patient was ineligible.
952	RECIPIENT PREPAYMENT REVIEW REQUIRED	15 - Payment adjusted because the submitted authorization number is missing, invalid, or does not apply to the billed services or provider.		Contact your program representative.

APPENDIX 1   EDIT CODES, CARCS/RARCS, AND RESOLUTIONS

Edit Code	Description	CARC	RARC	Resolution
953	BUYIN INDICATED ON CIS-POSSIBLE MEDICARE	22 – Payment adjusted because this care may be covered by another payer per coordination of benefits.	MA04 - Secondary payment cannot be considered without the identity of or payment information from the primary payer. The information was either not reported or was illegible.	**CMS-1500 CLAIM:** File with Medicare first. If this has already been done, enter the Medicare carrier code, Medicare number, and Medicare payment in fields 24, 25, 26, and 28 on the claim form. If no payment was made, enter '1' in field 4 and resubmit. **UB CLAIM:** File with Medicare first. If this has already been done, enter the Medicare carrier code, Medicare number, and Medicare payment in fields 50, 54, 60 on the claim form. If no payment was made, enter 0.00 in field 54 and occurrence code 24 or 25 and the date Medicaid denied.
954	RURAL BEHAVIORAL HLTH. SERVICES (RBHS)	141 - Claim adjustment because the claim spans eligible and ineligible periods of coverage.	N30 - Recipient ineligible for this service.	Person is enrolled in the Rural Behavior Health Services program and is not eligible for this service. Contact your program representative.
955	RURAL BEHAVIORAL HLTH. (RBHS) RECIP/SERV	B7 - This provider was not certified/eligible to be paid for this procedure/service on this date of service.		Person is enrolled in the Rural Behavior Health Services program and is not eligible for this service. Contact your program representative.
956	PROVIDER NOT RURAL BEHAVIORAL HLTH. SERV	38 - Services not provided or authorized by designated (network) providers.		Person is enrolled in the Rural Behavior Health Services (RHBS) program and you are not the RBHS service provider. Contact your program representative.
957	DIALYSIS PROC CODE/PAT NOT CIS ENROLLED	16 – Claim/service lacks information which is needed for adjudication.	N188-The approved level of care does not match the procedure code submitted	Attach the ESRD enrollment form (Form 218) for the first date of service to ECF and resubmit to program representative.
958	IPC DAYS EXCEEDED OR NOT AUTH ON DOS	B5 -Payment adjusted because coverage/program guidelines were not met or were exceeded.		Contact your program representative.
960	EXCEEDS ESRD M'CARE 90 DAY ENROLL PERIOD	16 – Claim/service lacks information which is needed for adjudication.	MA92 - Our records indicate that there is insurance primary to ours; however, you did not complete or enter accurately the required information.	Attach the statement from the Social Security Administration (SSA) denying benefits to the ECF and resubmit, or attach a copy of the patient's Medicare card showing the eligibility dates to the ECF and resubmit.
961	RECIP NOT ELIG FOR NH TRANSITION	141 - Claim adjustment because the claim spans eligible and ineligible periods of coverage.	N30 - Recipient ineligible for this service.	Contact your program representative.

APPENDIX 1   EDIT CODES, CARCS/RARCS, AND RESOLUTIONS

Edit Code	Description	CARC	RARC	Resolution
964	FFS CLAIM FOR SLMB/QDWI RECIP NOT CVRD	141 - Claim adjustment because the claim spans eligible and ineligible periods of coverage.	N30 - Recipient ineligible for this service.	Medicaid pays Medicare premiums only for recipients in these Medicaid payment categories. Fee-for-service Medicaid claims are not reimbursed.
965	PCCM RECIP/PROV NOT PCP-PROC REQ REFERAL	38 - Services not provided or authorized by designated (network) providers.	N54-Claim information is inconsistent with pre-certified/authorized services	**CMS 1500 CLAIM:** Contact the recipient's primary care physician (PCP) and obtain authorization for the procedure. Make the correction on the ECF by entering the authorization number provided by the PCP in field 7 (Primary Care Coordinator) and resubmit the ECF. **UB CLAIM:** Contact the recipient's primary care physician (PCP) and obtain authorization for the procedure. Make the correction on the ECF by entering the authorization number provided by the PCP in field 63 (Treatment Authorization Code) and resubmit the ECF.
966	RECIP NOT ELIP FOR VENT WAIVER SERV	141 - Claim adjustment because the claim spans eligible and ineligible periods of coverage.	N30 - Recipient ineligible for this service.	The claim was submitted with a Mechanical Ventilator Dependent Waiver (MVDW) specific procedure code, but the patient was not a participant in the MVDW. Check for error in using the incorrect procedure code. If the procedure code is incorrect, strike through the incorrect code and write the correct code above it. Check for correct Medicaid number. Submit the edit correction form. If the patient Medicaid number is correct, the procedure code is correct and a MVDW form has been obtained, contact the service coordinator listed at the bottom of the waiver form
967	RECIP NOT ELIG. FOR HD and SPINAL SERVICES	141 - Claim adjustment because the claim spans eligible and ineligible periods of coverage.	N30 - Recipient ineligible for this service.	The claim was submitted with a Head and Spinal Cord Injured (HASCI) waiver-specific procedure code, but the patient was not a participant in the HASCI waiver. Check for error in using the incorrect procedure code. If the procedure code is incorrect, strike through the incorrect code and write the correct code above it. Check for correct patient Medicaid number. If the patient's number is incorrect, strike through the incorrect number and enter the correct Medicaid number above it. Submit the edit correction form. If the Medicaid number is correct, the procedure code is correct, and a HASCI waiver form has been obtained, contact the service coordinator listed at the bottom of the waiver form.

APPENDIX 1   EDIT CODES, CARCS/RARCS, AND RESOLUTIONS

Edit Code	Description	CARC	RARC	Resolution
969	RECIP NOT ELIG. FOR ROOM AND BOARD	141 **-** Claim adjustment because the claim spans eligible and ineligible periods of coverage.	N30 - Recipient ineligible for this service.	This edit will occur only when billing for procedure code H0043. Check the PA number in field 3 of the ECF to ensure it matches the PA number on the authorization form. You may not bill room and board charges through Medicaid. Mark through this line in red. Deduct the charge from the total charge. Mark through both the Total Charge, field 27, and Balance Due, field 29, and enter the corrected amount for both. Be sure to make this correction in red. If the PA number on the ECF is correct, contact the local MTS office to determine if appropriate notification has been made to the MTS state office. Ask for the date the child's eligibility went into effect to ensure it corresponds with the dates of service for which you are billing. If the dates correspond and no corrections are necessary, submit the ECF. If the dates do not correspond, ask the case manager to update the child's eligibility to correspond to the authorization dates on the DHHS Form 254 you were provided. Then return the ECF for processing. If any other problems occur, contact your program representative.
970	HOSPICE SERV/RECIP NOT ENROLLED FOR DOS	16 – Claim/service lacks information which is needed for adjudication.	N143 - The patient was not in a hospice program during all or part of the service dates billed.	Service is hospice, but the recipient is not enrolled in hospice for the date of service.
974	RECIP IN HMO/HMO COVERS FIRST 30 DAYS	24 - Payment for charges adjusted. Charges are covered under a capitation agreement/managed care plan.		If you are a provider with the HMO plan, bill the HMO for the first 30 days.
975	FEE FOR SVC RECIP/PALMETTO SENIOR CARE	109 - Claim not covered by this payer/contractor. You must send the claim to the correct payer/contractor.		Contact Palmetto Senior Care at (803) 434-3770.
976	HOSPICE RECIPIENT/ SERVICE REQUIRES PA	B9 - Services not covered because the patient is enrolled in a Hospice.		**CMS-1500 CLAIM:** Contact Medicaid IVRS to determine who the Hospice provider is. Contact the hospice provider to obtain the prior authorization number. Enter the authorization number in field 7 on the ECF resubmit. **UB CLAIM:** Contact Medicaid IVRS at 1-888-809-3040 to determine who the Hospice provider is. Contact the hospice provider to obtain the prior authorization number. Enter the authorization number in field 63 on the ECF resubmit.

APPENDIX 1   EDIT CODES, CARCS/RARCS, AND RESOLUTIONS

Edit Code	Description	CARC	RARC	Resolution
977	FREQUENCY FOR AMBULATORY VISITS EXCEEDED	B1 - Non-covered visits.		Exceptions may be made to this edit under the following criteria: 1. An ECF must be returned within six months of the rejection with a copy of verification of coverage attached indicating ambulatory visits were available for the date of service being billed. The availability of ambulatory visits must have been verified on the actual date of service being billed or the day before. 2. If the visit code was a line item rejection and other services paid on the claim, the provider must file a new claim within six months of the rejection with a copy of verification of coverage indicating ambulatory visits were available for the date of service being billed. The availability of ambulatory visits must have been verified on the actual date of service being billed or the day before. 3. All timely filing requirements must be met. A provider has two options: Bill the patient for the non-covered office visit only. Medicaid will reimburse lab work, injections, x-rays, etc., done in addition to the office visit, **or** Change the office visit code in field 17 to the minimal established office E/M code, 99211, and accept the lower reimbursement. This code does not count toward the ambulatory visits.
979	FREQ. FOR CHIROPRACTIC VISITS EXCEEDED	B1 - Non-covered visits.		Contact your program representative.
980	H HLTH NURS CARE N/C FOR DUAL ELIG RECIP	141 **-** Claim adjustment because the claim spans eligible and ineligible periods of coverage.	N30 - Recipient ineligible for this service.	File your claim with the Medicare intermediary.
984	RECIP LIVING ARR INDICATES MEDICAL FAC	5 - The procedure code/bill type is inconsistent with the place of service.	N30 - Recipient ineligible for this service.	Verify patient's place of residence on date of service. If patient was not in a medical facility on date of service, contact your program representative.
985	RECIP NOT ELIG FOR CHILDREN'S PCA SERV	141 **-** Claim adjustment because the claim spans eligible and ineligible periods of coverage.	N30 - Recipient ineligible for this service.	Please check to make sure you have billed the correct Medicaid number, procedure code and that this client is in the CHPC program. If you have not billed the correct Medicaid number or procedure code, or the client is not in the CHPC program, rebill the claim with the correct information. If the correct information has been billed and you continue to receive this edit please contact your program representative.

APPENDIX 1   EDIT CODES, CARCS/RARCS, AND RESOLUTIONS

Edit Code	Description	CARC	RARC	Resolution
986	RECIP NOT ELIG FOR E/D WAIVER SERV	141 - Claim adjustment because the claim spans eligible and ineligible periods of coverage.	N30 - Recipient ineligible for this service.	The claim was submitted with an Elderly/Disabled Waiver-specific procedure code, but the patient was not a participant in the Elderly/Disabled Waiver. Check for error in using the incorrect procedure code. If the procedure code is incorrect, strike through the incorrect code and write the correct code above it. Check for correct patient Medicaid number. If the patient's number is incorrect, strike through the incorrect number and enter the correct Medicaid number above it. Submit the edit correction form. If the patient Medicaid number is correct, the procedure code is correct, and an Elderly/Disabled Waiver form has been obtained, contact the service coordinator listed at the bottom of the waiver form.
987	RECIP NOT ELIG FOR HIV/AIDS WAIVER SERV	141 - Claim adjustment because the claim spans eligible and ineligible periods of coverage.	N30 - Recipient ineligible for this service.	The claim was submitted with a HIV/AIDS Waiver-specific procedure code, but the patient was not a participant in the HIV/AIDS Waiver. Check for error in using the incorrect procedure code. If the procedure code is incorrect, strike through the incorrect code and write the correct code above it. Check for correct patient Medicaid number. If the patient's number is incorrect, strike through the incorrect number and enter the correct Medicaid number above it. Submit the edit correction form. If the patient Medicaid number is correct, the procedure code is correct, and a HIV/AIDS Waiver form has been obtained, contact the service coordinator listed at the bottom of the waiver form.
988	CRD PROCEDURE/DOS PRIOR TO COVERAGE	26 - Expenses incurred prior to coverage.		Call your program manager to see what the recipient's first date of treatment is. If dates of service on the ECF are prior to enrollment date, verify enrollment date. If enrollment date is correct, change dates on ECF. If enrollment date is wrong, submit a new enrollment form (DHHS Form 218) along with the ECF so the recipient's file can be updated.
989	RECIP IN HMO PLAN/SERV COVERED BY HMO	24 - Payment for charges adjusted. Charges are covered under a capitation agreement/managed care plan.		If you are a provider with the HMO plan, bill the HMO for the equipment or supply. Discard the edit correction form.
990	FP WAIVER RECIP/SERVICE IS NOT FP	141 - Claim adjustment because the claim spans eligible and ineligible periods of coverage.	N30 - Recipient ineligible for this service.	Make sure the Medicaid ID number matches the patient served. Check the diagnosis code(s), procedure code(s), and/or modifier to ensure the correct codes were billed. If incorrect, make the appropriate changes by adding a family planning diagnosis code, procedure code, and/or FP modifier. If this service was not directly related to family planning it is non-covered under the Family Planning Waiver and by Medicaid, therefore the patient is responsible for the charges.

APPENDIX 1   EDIT CODES, CARCS/RARCS, AND RESOLUTIONS

Edit Code	Description	CARC	RARC	Resolution
991	RECIP ISCEDC/COSY-LIMITED SERVS. COVERED	141 - Claim adjustment because the claim spans eligible and ineligible periods of coverage.	N30 - Recipient ineligible for this service.	Limited services are covered for this recipient. This is not a covered service.
993	RECIP NOT ELIG FOR PSC SERV	141 - Claim adjustment because the claim spans eligible and ineligible periods of coverage.	N30 - Recipient ineligible for this service.	Contact your program representative.
994	RECIP ELIG FOR EMERGENCY SVCS ONLY	141 - Claim adjustment because the claim spans eligible and ineligible periods of coverage.	N30 - Recipient ineligible for this service.	Recipient is eligible for "emergency medical services" only. Transportation services are non-covered for these recipients.
995	INMATE RECIP ELIG FOR INSTIT. SVCS ONLY	141 - Claim adjustment because the claim spans eligible and ineligible periods of coverage.	N30 - Recipient ineligible for this service.	Check DOS on ECF. If DOS is prior to 07/01/04 and service was not directly related to institutional services, service is non-covered. **UB CLAIM:** Only inpatient claims will be reimbursed.